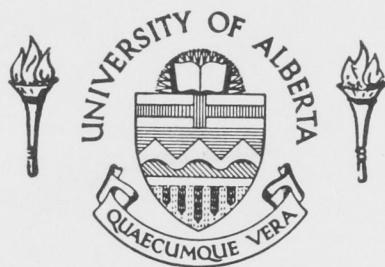


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Country Practice*

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President, Canadian Medical Association

This evening I would like to talk to you about the General Practice of Medicine in rural areas.

Naturally one may ask, what is a General Practitioner? He is defined as a doctor who does more than one line of work; or as a doctor who does not confine his work to any one branch of medicine. My own definition of the General Practitioner in rural areas is a doctor who treats every manner of illness, from dandruff to plantar warts. That is to say he is a good obstetrician, good medical man, good surgeon, good pediatrician and good psychologist.

He is a man of courage willing to put his knowledge and training against all emergencies even in the far distant places where, as you know, the doctor is all too often alone with one life in the balance, sometimes two lives.

Within our memory men graduated from college and went directly into the practice of medicine, where they proved the efficiency of their knowledge and training by trial and error. On the whole their experience was good, what they may have lacked in knowledge and training was more than compensated for by their kindness and the comfort they gave the patient and family.

Most of you will recall the old doctor of your youth, whose presence in the home gave the whole family a sense of security.

You will remember his bag of bottles of powders. You can still see him sitting at the lamp or lantern-lit table. Taking out one bottle and with his pen knife extracting a quantity of powder, placing it on a piece of paper, repeating the process from one or more bottles, then mixing the mass together, dividing the mass into little white or grey pills, wrapping each in a separate piece of paper. Giving his orders as to how the powders should be given. These innocent looking, evil tasting powders were very potent potions. One is left to speculate as to whether the powders cured, or whether the fear of more powders helped the patient to recover. In any case the powders did get the credit.

The dispenser of these powders was not only the doctor; he was the family friend, the councillor, the Father Confessor, the guardian of the portals of life, both the entrance and the exit. He was the giant of his community and district; the man who was sworn by and not at. The question is asked, How could these men stick it out? The answer I feel is that the tempo of life was slower;

with the wit and spice of life greater. I think every General Practitioner can recall some incident where he felt all in. Then some yarn or wise crack put a new vim into his heart, which helped him carry on, helped him forget his fatigue.

We are told that times have changed; that medical science has advanced so fast that our General Practitioners of the small country towns and out posts are a passing group who are not being replaced.

These giants of our profession loved and honored by the people of their own districts, admired by the town and city people for their courage, their vigor and tenacity; yet they are found wanting and below par in our hospitals. One is led to believe that the pendulum has swung too far. The people are awakening and demanding all sorts of care, services, medicines and auxiliary aids, which they expect George to pay for.

This change in attitude has led the best brains, in our profession, among the lay people, in every political party, to study the situation in an effort to bring forward some plan which will be fair to the giver and to the receiver at a reasonable rate.

It is sound practice to occasionally stop and take a look backward to determine where we are. Are we advancing, stationary or going back?

I feel we can look back over the past fifty years with a sense of pride in the work of our profession. General Practitioners, Specialists and Scientists. We glibly say our time has been one of glorious advance, seldom stopping to consider the work of our forefathers. Men like Pasteur, Lister, Harvey and others who laid the solid foundation for us to build upon.

The Canadian Medical Association has been looking back, looking to both sides, looking ahead, in an attempt to find the answer for the decline in interest in General Practice in small towns, country districts and out posts.

The consensus of opinion, as I see it, is that the chief fault lies in the way young men in medicine are taught in our colleges where all teachers are specialists. It would appear that these specialists in scattering their seeds of wisdom also create a yen in students' minds to emulate this or that particular specialist. Forgetting that these same specialists have been G.P.s or have put in long years of special training. This yen is carefully kept in the background. Oh! yes all are going into country practice until the last exam. is over and the student is no longer under control. Then the country, the small towns and the out posts can go to pot. The young medico is out after the long green and he goes where he can find the best

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living, for the least effort. Of course there are exceptions.

In talking this problem over with a college professor a few years ago (I realize now that this particular man saw before others the hand writing on the wall), I asked his opinion as to the change of attitude in our students in the outlook on a life of service and self sacrifice. His answer came quickly, We are not getting the country boys as we used to. The boys who were inspired by the rugged accomplishments of the old G.P.'s in the country. The boys who went into medicine with a desire and a preconceived idea of service to their fellow men.

This type of boy still exists but on account of lack of money he cannot compete with the city boys.

Our country boys are leaving the farms for high paid work in the cities. There they get the belt-line production ideas, together with shows, cars and other attractions. Soon the country is a long way off. Soon they lose their sense of pride in personal creation of goods such as our old fashioned (hand-made) artisans. Such as our old fashioned G.P. had when he pulled off some spectacular piece of work all alone in the country. The G.P. got a kick out of it, was too busy to write it up. He just went on his way.

About twenty years ago we heard the first whisper of health service by government.

In Canada we are fortunate in having one of the best public health services to be found anywhere. At any time the Department of Health may want to put in total coverage health insurance and they say the G.P. is to be the back bone of the scheme.

Our people are clamoring for more and better care. The question is often asked "How can I get away from all the specialists and get a good general practitioner who can look after my family's needs?"

Over the past three years the C.M.A. has been studying this question and it was decided to form a section of general practitioners within the C.M.A. The response to this idea has been very gratifying. The credit goes to Dr. Victor Johnson of Lucknow, Ont.

We feel that every doctor in general practice in Canada should get in on the ground floor of this section to help the so called back bone of medicine from becoming the coccyx (as a western M.D. put it), as has happened in the mother country, so our observers tell us.

This setting up of a section in general practice within the C.M.A. does not mean that the G.P.'s have their backs up, or that they are at variance with the specialists. G.P.'s and specialists both have a place in our scheme of medicine and to be successful must of necessity work together, at reasonable rates of pay for all groups.

The setting up of this G.P. section means that the G.P.'s themselves see the need of a concerted effort to keep the G.P. up to par and to encourage the young men and women to go into general practice under the aims and objects of this section.

We have such articles as these:

To promote and maintain high standards of G.P.

To encourage young men and women to prepare and qualify for general practice.

To preserve the right of the G.P. to engage in medical and surgical procedures he is qualified to perform. This means he should have entrance to a hospital.

To assist, encourage and provide post graduate study and training for G.P.'s.

To study all matters pertaining to G.P.

To assure hospital appointments for general practice.

Membership is open to all G.P.'s who are members of their local society, Provincial Society and the C.M.A.

It used to be a dictum in medicine that young men should go to the country for 5 or 10 years to get experience and then return to the centres of larger population. The dictum while I believe it is still sound has gone by the boards for two reasons. First, once a man gets into the country he is loath to leave. Something gets into his blood. The battle, the loveliness, the challenge of each case. The second reason, a sad one, the G.P. leaves the country and returns to the city, to find that he is almost a forgotten man. He finds it difficult to get into a hospital as a staff member because hospitals in cities are closed and unless a man has been taking post graduate work he has virtually no chance. This is a sad state of affairs which should be rectified.

I believe that every doctor has just as much right in a hospital as any other doctor, provided he is qualified, does reasonably good work, and is willing to accept a part of the responsibility of running and maintaining hospital.

I believe that every hospital, especially teaching hospitals, should have two or three country doctors as teachers; so as to give the embryo medico both sides of the picture. To attain this end will be one of the functions of the G.P. section of the C.M.A.

In my opinion any town can have a doctor if the people have three things: Unity, Co-operation and Vision. Let a community build a hospital, 10 beds to start, but planned so as to be easily enlarged as and when required. There will be no lack of doctors where there is a hospital. Always keep in mind that there are two essentials in any hospital. One, a trained hospital manager. Local people cannot and should not try to do this work. Two, a good laboratory, then you can have your operating room, case room, wards, etc. From the

manner in which our men are trained today, a good laboratory is mandatory. No longer is the case diagnosed by three or four senses. Sight, touch, ear and smell. In the old days that was the procedure. Nowadays we must have blood counts, smears, punctures, sputum, urine and feces tests. Then and then only will the modern man give a diagnosis.

You and I know that in the country the people do not care to submit to all these tests. The country people call a doctor. They expect services on the spot. Relief of pain. They expect to be better at once.

When a serious condition presents itself the country doctor often has to spend hours persuading the patient or his family and sometimes both of them to go to hospital for operation.

The operation saves the patient's life. The operation and the surgeon get the credit and the cash. The country doctor is left holding the bag.

There ought to be some way in which the work of the country doctor gets more recognition and remuneration. If you want the G.P. to remain in the country, other bones of contention which are continually arising are the night calls, the emergency calls, and obstetrics. Every doctor has his fill of these calls. Why? The night calls could have been made in day time but the family had no time to think of the sick. No, the farm work had to be done, the cows milked or the chores done or wait till father gets home late at night. Then, because the family rest is being disturbed, call the doctor. That supposedly tireless perpetual-motion man of medicine, who does not mind being up all night because he is accustomed to being up. A little forethought on the part of the people would avoid many if not all night calls, emergency and confinement calls excepted.

The emergencies. There are not many real emergency calls except those that occur from the injudicious mixture of gasoline, bacchus and speed.

Nearly every week the press blares forth with indignation because in these road emergencies a doctor cannot be found to answer so-called emergencies. At any accident every new arrival is full

of harmful suggestions. Mass psychology takes hold. Several people rush to phones and call their favorite doctor or, failing to get their first choice, they phone several others. The first doctor to arrive takes the case. If the others arrive, well they can go home with no remuneration for getting up in the middle of the night and driving several miles. When a doctor does arrive no one thinks to cancel all the other calls.

It is also common for doctors to answer calls of emergency only to find that some passing motorist has picked up the patient and whisked him off to hospital. Again the country doctor is left holding the bag.

In view of these facts can anyone wonder at the doctor becoming fed up and frustrated. All this could be avoided if a little common sense were used, if a little thought were given to the doctor who really tries to serve his area.

If we ever get an over-all health plan and doctors become responsible for a certain area or group, I feel that a lot of time and money will have to be spent in educating the public to make every effort to co-operate with the profession. There are just not enough doctors to run clock-punching shifts. If there were, I think the people would wait for the man of their choice.

If we have a health plan it must, to my way of thinking, be on a contributory basis. The public must be made to realize that the greatest asset of the plan is the general practitioner, who is a human being capable of just so many hours work in any twenty-four hours. If they overload this man and knock him out the public suffers as well as the poor G.P. because of lack of replacements. Even now replacements for country doctors are very difficult to find.

Therefore I submit that our whole health scheme rests squarely on the shoulders of our whole population who must show unity, co-operation and vision. By these means and these means alone can success be attained.

The whole creed of health must be understood by all concerned. All must strive to get the best results without killing the doctor.

Obstetrics

The Physiology of Reproduction The Endocrine Glands and Their Secretions

From the Faculty of Post-Graduate Studies of the Winnipeg
General Hospital in the Department of Obstetrics and
Gynaecology.

Section "A" No. 3

The Pituitary Gland

With Particular Reference to Its Influence on the
Female Reproductive Cycle

C. McCawley, M.D.

History

The pituitary gland was named by Vesalius in 1543 from the word *pituita*, meaning nasal mucous, the gland at that time being believed to secrete such fluid. In 1864, Willis, the Anatomist, and, in 1847, Magendie, associated the pituitary with formation and secretion of cerebro-spinal fluid. Lorain (1871), Pierre Marie (1886), Frohlich (1901), Frank (1912), Simmonds (1914), and Erlich (1916) associated various syndromes with lesions of the pituitary. However, theory and speculation did not give way to experimental evidence until work on hypophysectomized animals was begun. Paul-escio (1908) of France, Cushing (1910) of U.S.A., Aschner (1912) of Germany and Camus and Roussy (1913) of France, were early leaders in experimental work on animals and described effects of deprivation of pituitary function. In 1916, Smith and in 1919, Allan, described the effect of pituitary implants on hypophysectomized animals and this was later followed by the administration of pituitary extracts to both normal and hypophysectomized animals. In 1921 the brilliant work of Evans in California conclusively proved the presence of a growth-promoting hormone in the anterior pituitary. Smith of America and Zondek of Germany in 1926 independently showed that pituitary implants caused precocious ovarian development in immature rodents. In the past decade vast strides have been made in tracking down the functions of, and isolating the compounds secreted by the anterior pituitary. In 1937 luteotrophin was isolated by White, in 1940 luteinising hormone was isolated by Li, and in 1942 and 1943 corticotrophin (ACTH), by Li and Sayers.

Although the posterior pituitary has not been as dramatic in its history as the anterior, interest has recently been aroused because of its effect on body water metabolism. Posterior pituitary extracts were used for the first time in 1894 by Oliver and Schofer of England. In 1928, Kamm of U.S.A. separated a vasopressor and an oxytocic factor from the posterior pituitary. In 1937 the

anti-diuretic factor was demonstrated by Gilman, but this factor may be identical with vasopressin.

Anatomy

Gross: The pituitary gland is situated at the base of the brain, completely encompassed by bone, the sella turcica. It is attached to the hypothalamus on the floor of the third ventricle by the thin stalk-like infundibulum. The average weight of the gland in the human adult is .5 to .6 grams, but in multiparous women it may weigh as much as 1.0 grams. The hypophysis has two sources of origin: (1) from Rathke's pouch which is formed by the ectoderm of the primitive oral cavity and (2) from the diencephalon. The ectodermal portion gives rise to the anterior lobe and the diencephalon or nervous portion forms the posterior lobe. The gland is divided into three lobes, but in the human, the middle lobe is absent or vestigial, thus leaving:

(1) The anterior lobe, *pars glandularis*, or *adenohypophysis* which is continued into the infundibulum as the *pars tuberalis*.

(2) The posterior lobe, *pars nervosa*, or *neurohypophysis* which is continued through the infundibulum to connect with the hypothalamus.

Microscopic—The anterior lobe consists of epithelial cell nests supported by epithelial stroma. Sinusoids are present lined by reticulo-endothelial cells. The epithelial cells are presumably responsible for hormone secretion of the anterior lobe and are made up of three types:

1. Acidophils—containing acidophilic granules, 37-43%.

2. Basophils—containing basophilic granules, 7-13%.

3. Chromophobe or chief cells, 50%. These latter cells are thought to be the precursors of both the other types of cells. Whether or not a given chromophobe cell can produce either an acidophil or a basophil has yet to be shown.

The posterior lobe is made up mainly of the following structures:

1. Pituicytes—spindle shaped cells resembling nerve cells, but containing no Nissl bodies.

2. Unmyelinated nerve fibres coming through the infundibulum from the brain, possibly from nuclei in the hypothalamic region.

Blood Supply—A portal system of veins is present in the pituitary as well as a systemic system. This portal system will be mentioned in discussing the relationship between the hypophysis and hypothalamus.

The Hypothalamico—Hypophyseal System

There is increasing evidence that the hypophysis and the hypothalamus are related both

anatomically and functionally. Recognition of the relationship has led to the speculation that regulation of many body processes (e.g. metabolic), is governed by an interaction between the endocrine and the neurovegetative systems. Not enough definite knowledge is at present uncovered to prove this relationship, but increasing evidence makes it more and more prominent in explaining pituitary function.

The hypothalamus and the pituitary are close together, and both are derived, at least partially, from the diencephalon. Rasmussen describes a nerve tract running through the infundibulum to the posterior pituitary and claims that this tract is formed by the blending of two tracts from the hypothalamus, one from the anterior portion and the other from the posterior hypothalamus. (See accompanying sketch).

It has been suggested that fibres leading to the posterior pituitary, excite secretory function of the lobe and experiments have been performed that suggest that injury and stimulation to these tracts have a responding decrease and increase in the hormonal content in the lobe. Popa and Fielding present the view that the active principles of the pituitary glands are carried via the portal system of veins to the hypothalamic centres whose function is thereby affected. This evidence has yet to be confirmed. Much experimental evidence is put forth showing the effects on body metabolism, gonadal function, etc., of hypothalamic stimulation and damage. Here again, is pointed out the connection between the hypophysis and the hypothalamus, but as yet the evidence is conflicting and the issue is clouded.

Hormones of the Anterior Pituitary

There are six hormones of the anterior pituitary that have been proven beyond doubt and four of these have been isolated in pure form, while the other two have been prepared in highly purified extracts. These are listed as follows:

1. Follicle—Stimulating Hormone (FSH). This substance has been prepared in highly purified form and is found mainly in the anterior lobe of the pituitary pregnant mare serum, and the urine of castrates. It is characterized by its ability to stimulate the growth of granulosa cells in the ovaries of hypophysectomized animals. It does not prevent atrophy of the theca cells, nor does it cause secretion of folliculoids by the ovaries. In the male it stimulates growth of the semeniferous epithelium in both intact and hypophysectomized animals.

2. Luteinizing Hormone (LH) (Interstitial-cell-stimulating hormone chorionic gonadotrophin).

This hormone has been isolated in pure form and is found mainly in anterior lobe tissue, human placenta, and human pregnancy urine. It is characterized by its ability to:

(a) Transform mature follicles into corpora lutea.

(b) Stimulate growth of the theca cells of the ovary.

(c) Stimulate folliculoid secretion of the theca cells, and probably also of the granulosa cells and the corpus luteum.

(d) Stimulates development and testoid secretion of the interstitial cells of Leydig in the testes.

LH does not prevent atrophy of pre-existing corpora lutea, nor does it promote folliculoid secretion in them.

3. Luteotrophic Hormone (LTH)—also called luteotropin prolactin, lactogenic hormone. This has been isolated in pure form and is found only in any quantity in anterior lobe tissue. Its functions are:

(a) Maintenance of fully formed corpora lutea in intact or hypophysectomized animals.

(b) Causes these corpora lutea to secrete luteoid hormone.

(c) Stimulates secretion of the mammary glands, but not development of the breast tissue itself.

These three gonadotrophins are the main controllers of gonadal activity in the body and in which we are mainly interested. However, for the sake of completeness, the other anterior lobe hormones will be briefly mentioned.

4. Corticotrophic Hormone (ACTH)—Has been isolated in pure form. It stimulates growth and production of the adrenal cortex both in intact and hypophysectomized animals.

5. Thyrotrophic Hormone (TTH)—This hormone has not been isolated. It stimulates growth and hormone secretion of the thyroid gland in both intact and hypophysectomized animals. It is found only in anterior lobe tissue.

6. Somatotrophic Hormone (STH)—This growth stimulating factor was the first to be proven as due to a hormone formed in the anterior lobe and has been isolated in pure form. It stimulates somatic growth in both intact and hypophysectomized animals. Before ossification is complete, it promotes growth of bones and soft tissues in both length and breadth, but after ossification, it loses its power to cause longitudinal growth. It, too, appears only in significant amounts in anterior lobe tissue.

There are many more actions attributed to hormones of the anterior pituitary, but none of them are proven definitely to be caused by additional hormones, although claims have been made. To date it would seem best to attribute these actions to combinations of the known anterior lobe hormones until stronger evidence is available. Some of these other actions will be mentioned briefly:

1. Ovulation—inducing action.

2. Synergistic action—this is supposed to be an augmenting factor which increases the gonado-

trophic effect of L.H. This factor is now generally agreed to be small amounts of FSH.

3. Antagonistic Action—"Atresin"—thought to cause follicular atresia and inhibit the action of gonadotrophins.

4. Antiluteogenic Action—accelerates the regression of corpora lutea. Both the antagonistic action and the antiluteogenic action can be simulated by the intraperitoneal injection of purified preparations of FSH and LH.

Other actions of the anterior pituitary are: thymotropic, renotropic, nephrosclerotic, glucominerals, lipo-testo-corticotrophic, parathyrotrophic, mammogenic, anti-insulin, glycostatic, pancreatotropic, diabetogenic, anti-diabetic, etc.

Some commercial preparations of the anterior lobe gonadotrophins, or like substances are listed here. They must be given by injection since they are destroyed by enzymes of the gastrointestinal tract.

A. Anterior Lobe Extracts of Gonadotrophins:

1. Gonadtropic Factor—Armour, Ayerst.
2. Pituitary Gonadtrophin—Squibb.
3. Gynapoidin—Park Davis—This is a combination of Anterior Pituitary gonadtrophic extract plus chorionic gonadtrophin.

B. Luteotrophic Hormone—used to stimulate milk secretion.

- Prolactin—Armour, Ayerst, McKenna and Harrison, Harrison, Schering.
 Ambinon—Roche-Organon.
 Gonadophysin—Searle.
 Gynantrin—Searle.
 Ovatin—Endo Products.

C. Chorionic Gonadtrophin—prepared from pregnancy urine or placenta:

- Antvitrin S—P.D.
 Chorionic Gonadtrophin—Upjohn.
 Follutein—Squibb.
 Gonan—B.D.H.
 Koratrin—Winthrop.
 Lyovac Vacuoles—Sharp and Dohme.
 Pranturon—Schering.
 Pregnyl—Roche-Organon

D. Pregnant Mare Serum (FSH)

- Anteron—Schering.
 Antex—Ayerst, McKenna, Harrison.
 Gonadogen—Upjohn.
 A.P.L.—Ayerst, McKenna, Harrison.
 Serogen—British Drug House.

Post-Pituitary Hormones

The activities of the posterior lobe are three-fold:

- (a) Vasopressor.
- (b) Oxytocic.
- (c) Anti-diuretic.

Extracts of the posterior pituitary gland cause these three actions, but none of the hormones have

been isolated in pure form. The anti-diuretic principle seems to be intimately connected with vasopressin and there is a good possibility that the two actions are caused by the same substance. This is borne out by the fact that injections into laboratory animals of vasopressin in increasing amounts has an anti-diuretic activity that parallels the vasopressor activity. Highly purified preparations of vasopressin and oxytocin have the following activity:

Vasopressin: 200 pressor units and 10 oxytocic units per mgm.

Oxytocin: 250 oxytocic units and 5 pressor units per mgm.

Commercial posterior pituitary preparations are listed as follows:

Posterior Pituitary Extract — several companies	{ Contains 10 posterior pituitary units per c.c.
Infundin — B & W	
Pituitrin — P. D.	

Vasopressin is sold under the name "Pitressin" (P.D.) and contains 10 units of pressor activity and not more than one unit of oxytocic activity per c.c. Oxytocin is sold under the name of "Pitocin" (P.D.) and contains 10 units of oxytocic activity and no more than .5 units of pressor activity.

In considering the influence of the anterior pituitary upon the female, a few scattered observations are here mentioned. In the hypophysectomized immature animal, the ovaries and secondary sex characteristics do not mature. Hypophysectomy in the mature animal causes involution and atrophy of the ovaries and secondary sex organs. The ovaries become smaller in size; there is a gradual loss of function and the follicles develop incompletely and undergo atresia. The primordial follicles are unaffected, only later stages of development. The corpus luteum regresses in most animals following hypophysectomy. In pregnant animals the effect of hypophysectomy varies with the gestation, depending chiefly on the period of gestation during which hypophysectomy is performed. In some animals, abortion will result at any stage; in others only during the early part of gestation; in others still, if done during the latter part of pregnancy, the result is stillbirth or post-maturity.

On the other hand, anterior pituitary extracts or implants will cause a reversal of sex changes if given to hypophysectomized animals. If given to immature animals, precocious development occurs and if given to senile mice, the ovaries are reactivated and appear like those of mature mice.

The gonadotrophins of the anterior pituitary depend for much of their effect on the synergistic actions of one another. Good examples of this phenomenon are seen in the interaction of FSH and LH. FSH alone causes growth of the follicle, but no oestrogen production. Addition of small amounts of L.H. causes production of folliculoids. In order to produce ovulation in the experimental

animal, large amounts of FSH are required, and then ovulation is not always the result. If small quantities of LH are given, the amount of FSH necessary to cause ovulation is markedly decreased. For best results these must be given at a certain stage of follicle development. Ovulation, therefore, depends upon:

- (1) Development of follicles by FSH.
 - (2) LH to supplement the action of FSH at the proper phase of follicle development.
- Luteotrophin (LTH) also takes part in these synergistic examples in that its action is greatly augmented by folliculoids.

From the information on the pituitary that we have so far examined, it can be seen that great strides have been made recently in discovering its exact function, but there is still much conflicting evidence on many points. Alteration in function of any of the other endocrine organs also have their effect on assessment of the pituitary. However, if future investigation keeps apace of past investigation, the murky mist of endocrinology should clear,

and the empirical use of endocrines will become a thing of the past.

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The Hypothalamico-Hypophyseal System

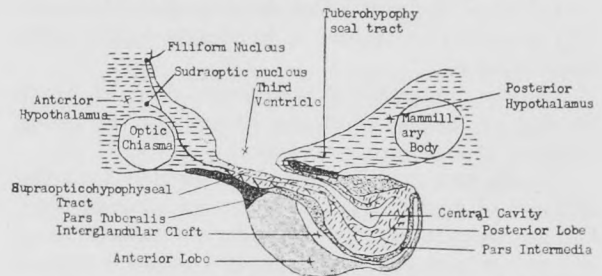


Diagram of Sagittal Section Through the Hypothalamus and the Hypophysis of the Cat.

Case Report

Hypertension and Unilateral Kidney Disease

Eric R. Gubbay, M.D. (Lond.), M.R.C.P. (Lond.),
F.R.C.P. (C)

A young woman aged 38 was referred by Dr. Lawrence Rabson, as she had presented symptoms of anginal pain. She had had two children but both pregnancies had been entirely normal. Her mother had died, aged 72, of "heart trouble." Her father had died in an accident. Three older siblings were all alive and well. Her previous medical history included a pelvic operation for removal of a fallen womb. In the spring of 1951 she had suffered with "inflammation of the bladder." For this she had been treated elsewhere with "satisfactory" results.

On examination the only abnormal finding was a blood pressure of 190/120. Routine blood count and sedimentation rate were normal. Urine analysis done on two occasions (including microscopic examination of the centrifuged deposit) was normal. Blood urea nitrogen 10 mgms. per cent. X-ray of chest negative. Her electrocardiogram showed an early left heart strain pattern. An intravenous pyelogram showed that the left kidney did not visualize. The function of the right kidney appeared satisfactory. Doubtful clubbing of the calyces was present. Accordingly a retrograde pyelogram was done by Dr. Melville Swartz. The right ureter was readily catheterized, and Dr. Swartz reported the resulting pyelogram to be

normal. It was not possible to catheterize the left ureter.

After consultation with Dr. Rabson and Dr. Swartz it was decided to explore the left kidney. This was done by Dr. Swartz, and a tuberculous left kidney, completely destroyed by caseating tissue, was removed. At operation it was seen that the ureter was sealed off by fibrosis, and this finding explained the absence of abnormality in the urine. Convalescence was uneventful, but up to the time of the report, two weeks after the operation, there had been no fall in blood pressure.

Discussion

Since the work of Goldblatt¹ and that of Wilson and Byrom², a number of cases have been reported where removal of a unilateral diseased kidney has led to the cure of the associated hypertension. However, this case is reported at this time merely to illustrate the principles that have been established in dealing with this type of problem.

Hypertension is rarely caused by unilateral kidney disease, and the routine request for an intravenous pyelogram in all cases of hypertension is extravagant. It is preferable to recognize the signals that alert the physician to the possibility that the particular patient with unexplained hypertension is not a case of essential hypertension. In this group the intravenous pyelogram should be ordered as a routine. These alert signals are:

1. Age—Platt³ has shown that hypertension in patients under the age of forty years is due to essential hypertension in only about 25% of fifty

cases studied. By contrast high blood pressure in patients over the age of fifty years is usually essential hypertension. This distinction applies also to those cases of hypertension in young people which present in a malignant phase. It has too often been assumed that these were cases of malignant essential hypertension.

2. Family History—It is known that essential hypertension is a familial disease. Platt³ has shown that the history may

(a) Give definite proof if it is clearly stated that a parent or sibling is known to suffer with hypertension.

(b) Be suggestive if a relative died of heart trouble or dropsy or stroke or asthma (probably cardiac) at an appropriate age.

(c) Be non-contributory. It is obvious that the absence of hypertension in younger siblings may be non-contributory, for they may not have reached the age where the latent genetic factor becomes apparent. The death of a parent at an early age has the same significance.

(d) Be clearly negative.

3. Previous Medical History — Any previous history of kidney disease is clearly a warning that the hypertension may have been so caused. Care should be taken in eliciting such a history, and any single symptom of urinary disturbance (frequency, pain, haematuria, bladder trouble, stones, etc.), should be regarded as highly suggestive.

In the case reported above, the young age of the patient, the absence of hypertension in three older siblings, and the previous history of bladder trouble were collectively strong evidence against the diagnosis of essential hypertension. Therefore the demonstration of renal pathology, in spite of a repeated normal urine analysis, was not surprising. It must be confessed, however, that the presence of a unilateral non-functioning kidney was particularly gratifying, as it suggested the possibility of important therapeutic success.

When the association of hypertension and unilateral kidney disease has been established, the practitioner is confronted with the next problem. "Is surgery indicated?" The answer to this question has been ably summarized by Langley and Platt.² "If evidence of unilateral disease is found, in nearly a third of the cases there will be surgical indications for nephrectomy, such as the presence of a large hydronephrosis, and the decision in favour of operation will be relatively easy. In the remainder a non-functioning kidney on one side with good function on the other is the most

promising indication for success. In all cases the total renal function should, of course, be within normal limits. In doubtful cases atrophic pyelonephritis, if there is reasonable evidence that it is unilateral, is more likely to meet with success than calculus or hydronephrosis.

If other indications are clear, age by itself is no contra-indication to operation, neither is the knowledge that hypertension has already existed for a number of years. Nevertheless the decision in favour of operation will be more confidently made in young persons, since a larger proportion of them are suitable. Papilloedema is not a contra-indication to nephrectomy. A family history strongly indicative of hypertension in a middle aged or elderly subject contra-indicates operation unless the evidence of unilateral disease is abundantly clear. A history of pregnancy toxæmia has the same significance. Finally, in some cases the operation may be justifiable even though the indications are doubtful on account of the youth of the patient and the severity of the hypertension, the prognosis being extremely unfavourable if no intervention is attempted. Unexpected successes have sometimes occurred in this way."

The reader who is interested in this problem will gain further information from a study of the papers listed in the references given below. Homer Smith's⁵ sceptical review of the subject is a corrective against undue surgical enthusiasm in this field where occasional brilliant successes have been reported. (Nearly half the successes that have been reported have been due to the removal of a unilateral pyelonephritic process. And yet patients are seen too frequently who die in uraemia due to active or inactive pyelonephritis. The urine may be sterile but the pyelogram reveals the distortion of the calyces due to a burnt out pyelonephritis. "Inflammation of the bladder" had been treated with apparent success, but follow-up urine analyses would have revealed the true state of affairs. A plea is therefore here repeated for careful follow-up studies in all patients with urinary infection.)

This paper was given at the Clinical Luncheon at the Misericordia Hospital, on the 13th November, 1951.

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Paediatrics

Suggestions for the Treatment of Cerebral Palsy in Manitoba*

J. K. Martin, M.R.C.P.

It is necessary when planning the care of spastic children, starting, as is logical, with the pre-school age group, to look to the future of these children. They must not be helped so far and then find nothing is available. Education within the school system is necessary at all grades, vocational advice and training must be available, and where required, help for the adult provided. Cerebral palsy varies in its manifestations and severity and in any scheme, account must be taken of this. Hence a central organization is essential for the economic and efficient co-ordination of the many services which will develop. Cerebral palsy is only one of the many crippling diseases starting in childhood and it should therefore be linked with the other services provided. Again, the whole is better guided by a single organization. By this means a fairer allocation of financial help can be provided as the various afflictions catch the popular imagination and gain its support. Above all it must be realized that cerebral palsy is not a curable condition and each patient's functional capacity is limited. The only effective treatment lies in its prevention. To this end research must be encouraged and supported.

Possible services, personnel, keeping of records, finance and research are discussed in the ensuing paragraphs. This is not intended as an exhaustive review, but rather to emphasize certain aspects for consideration by the Society in promoting a scheme for the care of children with cerebral palsy.

Services

1. Nursery Schools

In the early years of life these children are beings apart from the normal child by reason of their physical handicap. They cannot enjoy the varied experience of life and have not the opportunity to give and take or to learn from others of their own age. Indeed the parents themselves may over-protect the child through misguided pity, or from feelings of shame and guilt. To bring such children together under the guidance of a trained nursery-school teacher, aided by sympathetic but not necessarily skilled helpers, is of enormous value to their progress and development. Marked improvement occurs even without any specialized therapy, though of course expert medical supervision should be available. For many children

this alone is sufficient, for others, speech therapy, physiotherapy and occupational therapy will be necessary as it becomes available. The formation of nursery schools is the first step and should not be delayed because of lack of therapists. Moreover the municipal authorities should be made aware of the value of such schools as ultimately, such are properly their responsibility.

2. Special Schools

Ideally the aim should be to enable these children to compete in a normal school environment, and in a proportion of cases this will be possible.

For those of school age unable to attain such standards, special schools, or special classes within ordinary schools, should be available in strategic areas in the City and the Province. Such classes or schools should take care of all types of physically handicapped children. Some will go directly into special classes and others will require some specific training before doing so. Every child who has a good mentality, however physically disabled, should be given a trial period of varying length, to see whether he can improve sufficiently to benefit from education in a special class. If, however, such an objective is not attainable, he must be replaced by others more likely to profit from these facilities. Alternative procedures can be made available in his case.

3. Vocational Training

From the time at which an affected child comes within the educational system, consideration must constantly be given to the extent to which that child will be able to earn his own living and the vocation for which he is most suited. One of the tragedies already evident from centres which have been in operation for some years is the individual who, with the help and devotion of parents and teachers, has passed through high school, and even college, only to find that he has chosen an unsuitable training and is unable to procure employment.

For the majority, scholastic achievement is best stopped at high school level or even below, and instead, time devoted to a vocation suited to their disability. For instance a child with athetosis (writhing movements) is usually much worse under crowded conditions, or in positions where it is necessary to interview others. For these and other types special training, sheltered workshops, or even colonies or institutions, such as those for the blind and deaf, may need planning.

4. Out-patient Treatment Centres

In order to provide treatment for the largest number, attendance for a few hours so many times a week is best provided within one or more of the hospitals. This has the advantage that other ser-

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vices and consultations are easily available. Moreover, other types of disability are also being treated, and the therapists benefit from the variety. It is seldom that daily treatment at such a centre is required. For one thing, it is often too exhausting for the child. For another, there is nothing mysterious or magical about physiotherapy. The parents can be trained to carry out such exercises as are necessary within the home, with equal benefit to the child. In one centre visited, 40 children were being treated in half-day sessions by one physiotherapist, one occupational and one speech therapist, together with unskilled helpers. The number of children that an individual therapist can train depends upon the severity of the case and number of attendances required. In many cases one visit a week is sufficient, for others group therapy is more suitable.

5. Treatment Within the Home

A great deal can be done within the home. Special apparatus such as walking bars, special chairs and tables can be provided at low cost, or the father advised how to make them. A specially trained nurse or a physiotherapist can visit the home and teach the parents what they should be doing for their child. Such a programme is particularly applicable to rural areas or under conditions where transport to a treatment centre is impractical. It can also be used for those very severely handicapped children who do not fit into a scheme of nursery or school training. In these latter cases the burden on the parents can be relieved enormously if all that is achieved is that the child can learn to feed himself and perform the other simple essentials of living. A patient who can sit up is easier to care for than one who only lies, and one who walks simpler than one who sits. Further, if such a patient is later admitted to an institution the amount of care, and consequently the cost, is much reduced.

6. Centres Run by Parents

Another humane and wise provision for the very severely handicapped, is some organization run by the parents themselves. Imagine the relief to the parent of a completely helpless child if he or she can share that burden with others, can be encouraged and advised by expert opinion, and, with efficient planning, be totally free for the odd half-day. All that is necessary is room space, an enthusiastic organizer and the co-operation of the parents.

7. Residential Schools

Those residential schools which exist justify themselves on the grounds of intensive therapy, research, training of therapists, distance from, and unsatisfactory conditions in the home. In the States the cost is about \$5 000 per year per child as against \$1,500 for a day nursery. Such institutions are therefore an expensive luxury and should

only be developed later in any scheme. This is not to say that they do not serve a useful purpose.

8. Mobile Units

A team comprising the doctor, and a therapist in each branch can visit strategic centres in rural areas. Local doctors and nurses are notified and children with cerebral palsy are referred. Examination, assessment and recommendations are made by the consulting doctor. The recommendations are implemented by the local doctor and therapists. The latter remain for a varying period until the parents are sufficiently conversant with the methods to follow. Such centres may be visited two or more times annually depending on the needs. Such a method also provides an opportunity for promoting interest amongst doctors, parents and clubs. Many small towns will subsequently start their own organizations, following which the mobile teams are free to concentrate elsewhere.

9. Summer Camps

Summer camps provide a useful means of "socializing" these youngsters—teaching them the give and take of group environment. Further, they have greater opportunity to develop their own initiative than at home, and they are mixing with other types of crippled children.

10. Parent Education

Parent education is one of the fundamental needs in any organization of this type. The parents desire it and they learn a healthier attitude towards their problem, from which the children will benefit. They can be a driving force to stir the public authorities to action and achieve objectives which a voluntary society would find difficult. Under suitable guidance some parents could act as volunteer workers.

11. Diagnostic Clinics and Follow-up

Such clinics are essential if the child is to be treated to advantage and the best use made of existing facilities. Proposals regarding the personnel are discussed in the next section. Such clinics should be set up within existing hospitals, and most suitably for a start, such a clinic could be available one morning a week at the Children's Hospital.

12. Co-ordinating Council for C.P.

From the outset a Co-ordinating Council for the treatment of C.P. should be in existence. The council can advise on organization, suggest standards, promote research and ensure that services throughout the Province are integrated. Representatives from all hospitals or institutions treating cerebral palsy should be co-opted. To implement this a full time executive director is necessary as discussed under personnel.

13. Equipment

Such items as relaxation chairs, standing tables, parallel bars, reciprocating skis to mention a few

will be required in ever increasing numbers. Consideration should be given to workshops within which many of these articles could be made. A training programme should not be jeopardized by lack of equipment. It is possible that herein lies a useful function for vocational training or sheltered work shops. Disabled workers could well be employed.

Personnel

1. Medical Personnel

Every child is best seen initially, and possibly at intervals, by a team of doctors—a screening or diagnostic committee. The team best suited would consist of a neurologist, a paediatrician, an orthopaedic surgeon, and a psychiatrist. At first sight such a conglomeration of doctors may seem cumbersome, but experience shows that a much more balanced outlook is maintained by a group rather than by an individual. The efficiency of treatment and organization is thereby enhanced. The members of the team examine and record their recommendations—several children being seen at each clinic held. They can then meet bi-monthly, or as often as is necessary, to decide on a plan of action and inform the parents of their proposals.

At any treatment centre it is advisable to have one doctor attending weekly. He can then watch the progress of the children, direct their treatment, deal with any problems arising and organize regular conferences with the therapists. The person ideally suited to such a role would be a specialist in physical medicine. In Manitoba there are no such specialists available, but consideration might well be given to encouraging such a man to enter practice in this area. If hospital appointments were available, and possibly a part time salaried appointment offered, the inducement would be strong. In the interim any one of the types of specialists mentioned in the diagnostic team could adequately fill the position. Each child is then assured of thorough consideration at all times and periodically should be reviewed in detail by all concerned in order that the best use of existing services is made.

2. Cerebral Palsy Co-ordinator

The services of a therapist or social worker should be obtained to fill this position. The functions of such a person would include interviewing parents, making financial arrangements, advising how and where treatment and consultations may be obtained, organizing a central register of patients, the filing and keeping of records, arranging home visits and helping with the plans for education of parents and the public. Such a co-ordinator would also act as executive to the co-ordinating council. The medical personnel would thereby be spared a great deal of administrative detail and duplication of service throughout would be avoided. Such a person should be ap-

pointed by the Crippled Children Society so that services for spastic children are also co-ordinated with service for other types of cripples.

3. Brace-maker

Many of these children require braces. Such equipment is expensive (up to \$300 per child), needs constant adjustment to be efficient, has only a limited life—usually 1-2 years, and is highly specialized. At the follow-up clinics the brace-maker needs to be in attendance. Many adjustments can be made at the time. Failing this, instructions can be given direct and mistakes, costly in time and money, are avoided. If a firm of brace-makers are employed one man should devote himself to this work. Ideally a brace-maker should be attached to a hospital with his own work shop and assistant. This improves efficiency, reduces delays and is probably cheaper. Whatever method is employed the services of a brace-maker are essential before full treatment of "spastics" can be undertaken.

4. Therapists

Unskilled workers will be used in nursery-schools to help with the day to day care of the children. The possibilities of training certain of these workers to act as therapists under guidance should not be lost sight of. Just as the parents can be taught to treat their own children between visiting the therapists, so assistants could carry out many simple manoeuvres.

Records

Adequate records and progress reports on every child must obviously be maintained. The nature of the records will be determined from time to time by the medical committee concerned with this work. It is essential, if they are to be of any value, that they be standardized, when various hospitals in the city or province start their own treatment centres. The C.P. coordinator again serves a useful function in this respect.

Apart from written records probably the best means for judging the progress of the more severe cases is a short moving film.

In order to have a guide to the numbers for whom provision has to be made every doctor should be required to register information regarding any crippled child of any age. Such a central register is properly the responsibility of the Department of Health.

Finance

Financial support will be both private and public. At all times the authorities concerned should be constantly reminded of their responsibilities. Local clubs or parent groups in rural areas should be arranged to support some objective. They may be able to provide for a nursery school, pay the cost of braces for the children in their area, contribute towards the expenses of the mobile

team or pay cost of transport to a rural centre or to Winnipeg where necessary. At any rate they should be encouraged to make some contribution.

The other point to be considered is the contribution of parents towards the cost of diagnostic and treatment facilities. The majority of people can contribute something, however small, and in doing so will value the services more. Many parents will afford a full consultation fee when seeking the advice of the diagnostic centre.

Research

As has already been remarked in the introduction, provision of the encouragement and financing of research should be regarded as of paramount importance. A comprehensive committee should be formed having as its members medical men, lay men and government officers. The medical men would include those particularly interested in the work on spastic children and would promote and suggest lines of research. The lay members with the officials, would be influential in solving financial and administrative problems. The co-operation of men in many different branches of medicine will often be necessitated. One can imagine the contacts necessary when mentioning virus studies in early pregnancy, genetics, rhesus factors and neuro-pathology. Parents can help in such work not only financially, but when suitably educated in its importance, in allowing for post-mortem studies in applicable cases. Many voluntary organizations will be found only too keen to support varying projects—some may be short term and cost little, others will take years to achieve.

Summary and Conclusions

In conclusion, in order to implement planning, and in particular to be in a position to commence some active programme in the near future, the following suggestions are submitted. The two keystones to any programme are the appointment

of a "Cerebral Palsy Co-ordinator" and the formation of a diagnostic team. The latter would also work and advise in conjunction with the cerebral palsy committee together with members from any hospitals or organizations who wish to treat cerebral palsy. An outpatient diagnostic clinic will have to open several months before treatment centres commence work.

Ideally, 2 or 3 nursery schools should be established in different parts of the city and children brought from these to an out-patient treatment centre at the Children's Hospital. If, however, no more is available at the start than the existing facilities, i.e., the Nursery School at the Children's Hospital, it is suggested that children attend in groups of 10 for half-day sessions. By this measure 40-60 children could be treated instead of the 10 as at present.

While all the above require urgent consideration, steps could be taken to implement other features of the report as thought necessary. The services of a brace-maker and employment of sufficient therapists are a high priority, as is the co-operation of the School Board in establishing special classes in schools.

Finally, it is emphasized that the views expressed in this report are purely personal and as such, intended only as a guide. The means by which an organized scheme can best be promoted may well determine the approach. There are many experienced workers and organizations in this field from whom advice can be obtained. In particular, the resources of the National Society for Crippled Children and Adults in Chicago are a valuable source of information. An excellent library, reprint services, personnel registry, to mention a few, are located at the headquarters. Short courses, such as the one run by Dr. Perlstein of Chicago, are available to medical men. Conferences take place for all types of personnel involved in this work.



Clinico-Pathological Conference 70

Medical Department, Deer Lodge Hospital

Mycotic Aneurysm of Innominate Artery

22 March, 1891—Date of birth.

1917—G.S.W. Entry point: Small scar lower Rt. anterior neck. Exit: L. Shoulder.

1918—Pension: Ankylosis L. Shoulder.

1927 and 1928—Operations on Lt. Shoulder performed in St. Boniface Hospital.

15 April, 1950—Admitted to Deer Lodge Hospital.

Complaints: (1) Pain: Rt. Scapula, (a) Duration, 3 days; (b) Type, dull ache.

(2) Pain: Radiation from Rt. Scapula; up Rt. lateral aspect of neck. (a) Duration, 2 days; (b) Type, sharp stabbing; (c) Initiated by, cough or swallowing liquids.

Functional enquiry and physical examination not suggestive of pathology.

Laboratory

Blood—Wt. Negative. Hgb 94%, WBC 13,000, Polys 70%, B.S.R. 70 mm, Repeat 80 mm.

Urinalysis—Negative.

Sputum—No A.F.B. Culture—Neisseria catarrhalis.

7 May, 1950—Discharged from hospital. Diagnosis: Myositis Rt. latissimus dorsi.

28 May, 1950—Acute onset: Unproductive cough, chills, feverishness, anorexia, pain, upper sternum.

29 May, 1950—Admitted to Deer Lodge Hospital. Admission Diagnosis: (1) Suspect influenza; (2) Possible meningitis. T. 103.½°, P. 96, R. 30. Lumbar puncture: C.S.F. and dynamics, negative.

30 May, 1950—Sudden onset of burning pain between sternal and clavicular origins of right sternomastoid muscle, following which he had two drachms bright red hemoptysis. Chest clinically negative. X-ray chest reported essentially negative.

31 May, 1950—No local E.N.T. source to account for blood. Continued pyrexia 100° to 104°. On penicillin.

6 June, 1950—Recheck chest x-ray reported a homogeneous density 2.5" in diameter extending out from R. superior mediastinum which, in retrospect was acknowledged present in considerably decreased size on May 30 plate. Small rounded homogeneous nodule 7 mm. in diameter in L. lung field not previously apparent was also reported. Radiologist's opinion: "This would appear to represent a secondary tumor formation."

Laboratory

Blood—Hgb 97%, WBC 12,500, Polys 86%, B.S.R. 88 mm.

Urinalysis—Negative.

Mantoux: 1:10,000-1:1,000, both negative.

7 June, 1950—Hemoptysis: four ounces of dark clotted blood. Developed hoarseness. R. arytenoid immobile but no growths, swelling or excoriation seen to account for bleeding. Temperature: Swinging 99° to 101°. Pulse 100. Respiratory rate 25. No significant L.O.W.

10 June, 1950—Terminal profuse hemoptysis lasting 15 minutes.

Diagnostic problem: (1) Pyrexia of unknown origin. (2) Pulmonary tumor N.Y.D. (3) Etiology of fatal hemoptysis.

Pertinent Autopsy Findings

The thoracic contents were removed en masse. The trachea and main bronchi were filled with blood. On opening the aorta and the main branches arising from the arch, an incontinent saccular aneurysm of the innominate artery was noted. The aneurysm pointed postero-laterally and at its site of rupture the parenchyma of the right upper lobe of the lung was atelectatis and infiltrated with dark red clotted blood. No other gross pathology was noted.

Microscopic section of the innominate artery at the site of aneurysm showed necrosis of all but the adventitial layer which was thickened by fibrosis and infiltrated with lymphocytes, plasmocytes and polymorphs amounting in places to acute inflammation.

Autopsy Diagnosis

Mycotic aneurysm of innominate artery with rupture into upper lobe of right lung resulting in fatal hemoptysis.

Differential Pathology of Acute Chest Pain

It has been variously reckoned that pain in the region of the chest is present in 15-25% of all adult patients who are sufficiently ill to require hospitalization, and that discomfort in this area is probably more common than in any other region of the body except the abdomen.

Physicians who deal with hundreds of cases in which chest pain is a prime factor in differential diagnosis are unanimous in agreeing that the history is in most patients the single most important method of examination and is in many patients more important than all other procedures combined.

If we wish to express what we feel in the presence of environmental change we make use of suggestive or imaginative description. In narrative literature, description must accomplish what is accomplished on the stage by scenery, music and action. Exposition of the symptom of pain is so important as a basic guide to diagnosis that it is rather appalling to note with what careless

abandon histories are taken as far as pain description is concerned. Only by imaginatively feeling the symptom as best we can ourselves can we record for others understandable symptomatology.

For example, out of general interest, we have compiled a short glossary of words not uncommonly used to modify types of pain. Does not chest pain when modified by one or more of these terms, convey increasing reality?

Sharp, stabbing, tearing, throbbing, stinging, burning, breath-catching, colicky, constricting, steady, miserable, cutting, nagging, squeezing, oppressive, excruciating, lancinating, exhausting, insurgent, disabling, monotonous, pounding, deep-seated, suffocating, nauseating, pulsating, distressing, reflected, referred, darting, raw, indefinite, piercing, paroxysmal, superficial, masochistic, dissecting, searing, chilling, crushing, grinding, neuralgic, erosive, knife-like, intermittent, intractable, rhythmic, and many, many more.

Of course chest pain must also be catalogued according to site, onset, duration, intensity, character, aggravating factors, extent of relief by different means, and associations, reference, seasonal influence and so on.

I. Gastro-Intestinal Pathology as a Source of Chest Pain

Depending on the type of practice engaged in, the physician will find esophageal pathology responsible for about 3-4% of the instances of chronic or recurrent chest pain.

Certain generalizations may be offered concerning chest pain induced by disorders of the esophagus:

1. Disorders of the esophagus are frequently painless but in some instances the pain may be of great severity.

2. Dysphagia is usually present but is absent in many cases. In peptic ulcer of the esophagus with or without hiatal hernia, pain is the early symptom while difficulty in swallowing appears late. The reverse is usually true in esophagospasm and in cases of carcinoma of the esophagus.

3. Esophageal pain is likely to consist of a feeling of burning, or of fullness, distention or constriction.

4. The most common location for esophageal pain is the lower substernal region but it not infrequently radiates to the epigastrium or to the region of the dorsal spine. However, as was pointed out by Moersch and Miller, the pain may be very widespread; may radiate to the face, ear or more commonly to the neck, shoulder, arm and hand. According to the same authors, pain in the forearm and hand is likely to be localized in the radial rather than in the ulnar side. This point may be of some differential diagnostic value with respect to angina pectoris.

5. The duration of the individual attacks of esophageal pain is very variable. At times the discomfort lasts only a few seconds, while in other instances it endures for weeks.

6. Factors which may precipitate esophageal pain include swallowing and the recumbent position. In ulcer, spasm, carcinoma, stricture and scleroderma, swallowing may initiate or aggravate the pain.

In esophageal ulcer the recumbent position favors regurgitation of acid and causes increase in pain.

7. A common finding pointing to an esophageal lesion is difficulty in swallowing when the patient is lying down. Here gravity does not aid the descent of the food and any lesion which interferes with peristaltic waves tends to allow food to be trapped when the patient is in the recumbent position.

8. Among the factors which tend to alleviate esophageal discomfort are antispasmodics, particularly those of the atropine group, and assumption of the upright position. This is especially the case in those patients with peptic ulcer of the esophagus associated with congenital shortening and hiatal hernia. Some patients are relieved of pain at night by elevating the head of the bed.

Pain in the chest arising from stomach pathology may be severe and simulate angina pectoris but usually the patients consult a physician more because of concern over the possible significance of the pain rather than because of the degree of discomfort itself. The usual site is the left lower anterior chest although rather wide pain distribution is occasionally seen, the pain being carried along pathways from contiguous structures such as the diaphragm, esophagus and pericardium. The duration is usually more than an hour and the relation to digestive function is usually striking.

Reproduction of the pain is at times a valuable procedure in differential diagnosis. Inflation of the stomach will simulate exactly the discomfort ordinarily caused by aerophagia, pylorospasm or gastroptosis. Relief by atropine is the rule.

Harrison summarizes the chief clinical manifestations exhibited by patients who have chest pain as a result of gastric distention due to functional disorders: "Although the patient may be of either age or sex, most of the individuals with this syndrome are middle-aged females. Anxiety and palpitation are commonly associated symptoms. The discomfort sets in when the patient is lying on the left side and it usually consists of a feeling of fullness which is likely to be located in the left lower anterior chest, but which may have the typical distribution of pain due to coronary disease. The duration is more variable and is often longer than in the case of attacks of angina pectoris. Emotional disturbances and eating often induce

the discomfort which may be relieved by expulsion of flatus or by vomiting."

The smaller hiatal hernias are more likely to produce pain resembling angina than the large and this must be considered in bizarre cases of chest pain during the last trimester of pregnancy. The duration of pain due to hiatus hernia is very variable, attacks lasting from a few minutes to as long as three days. A sense of fullness or constriction commonly associates and all cases are aggravated following large meals. The pain is not relieved by nitroglycerine.

Cascade deformity of the stomach produces pain similar to that of hiatus hernia. The pain has a tendency to come on after small amounts of food and may disappear when additional food is taken. Relief is obtained by emptying the large bowel in a number of cases; presumably the cascade deformity is produced by a distended splenic flexure.

It is exceptional for gastric diverticula to produce chest pain.

The tendency with disorders of the stomach to produce pain when the stomach is distended and for relief to be afforded by belching or vomiting is characteristic. Acute indigestion following dietary indiscretion often incites chest pain and breathlessness.

Cholecystitis and cholelithiasis and chronic pancreatitis may at times present the picture of chest pain and differential diagnosis will depend largely upon keeping the possibilities in mind.

II. Myocardial Pathology as a Source of Chest Pain

Angina pectoris will, in any series, embrace the largest single group of patients presenting with acute chest pain.

A brief review of the mechanism for initiation and maintenance of cardiac pain may be interposed at this juncture.

The afferent pathways for cardiac pain begin in sensory nerve endings present in the adventitia of the coronary arteries and questionably in the myocardium, endocardium and epicardium. The nerve fibers collect in the superficial and deep cardiac plexuses and travel by way of the middle and inferior cardiac nerves to the cervical sympathetic ganglia and by way of the thoracic cardiac nerves to the upper four or five sympathetic ganglia. Since there are no white rami communicantes to connect the cervical sympathetic chain with the spinal cord, these cardiosensory fibres pass down the chain to the upper thoracic ganglia before proceeding to reach their cell bodies in the posterior root ganglia. After entering the cord, the spine-thalamic tracts convey impulses to the thalamus. Cortical projection of pain impulses from the thalamus is predominantly to the post-central gyrus.

Somatic reference of cardiac pain, has two theories to account for the common referral to the jaw, neck, chest, to either shoulder or arm down to the fingertips, to the back and to the epigastrium. These are that it is due either to poor localization by the cerebral cortex or to an "irritable focus" in the spinal cord. Sir Thomas Lewis is the chief proponent of the first of these two theories. He states that segmental reference of visceral pain to "regions that are relatively superficial, regions from which we are habitually receiving sensory impressions and which are endowed with some positional sense" is natural enough. The irritable focus theory of Ross, Head and MacKenzie proposes that painful visceral impulses on reaching the spinal cord set up a disturbance or irritable focus which extends to nerve fibres from the body surface.

Subject to the error inherent in all generalizations it may be stated that a pain lasting for only a few seconds or for more than an hour is not likely to be due to angina pectoris. The pain usually has a constrictive element although about one-fifth of cases experience only a dull ache or feeling of warmth. A lancinating character to the pain almost rules out angina pectoris, as does any pain which bears a direct relationship to coughing, laughing, yawning or other respiratory effort. The relation to effort is usually obvious with relief by rest.

The occurrence of chest pain due to conditions other than angina pectoris in patients who also have chest pain due to angina pectoris must be borne in mind and is not uncommon.

Pain due to coronary artery occlusion and myocardial infarction is always, of course, the first diagnosis to exclude before entertaining the less urbane and hence no particular reference need be made at this point.

III. Aortic Pathology as a Source of Chest Pain

Aortic stenosis and insufficiency due to syphilitic aortitis are well known causes of acute, oppressive, paroxysmal substernal pain.

Dissecting aneurysm in the majority of cases displays its initial symptom as that of sudden severe, tearing substernal pain which radiates to the interscapular region.

Saccular aneurysms of the thoracic aorta may produce bizarre types of chest pain, often characteristic on the basis of extreme variability.

IV. Mediastinal Pathology as a Source of Chest Pain

Mediastinitis, mediastinal tumors and spontaneous mediastinal emphysema have pain as the chief complaint in nearly all cases. Changes in position and deep respiration markedly accentuate the pain.

Likewise acute serofibrinous pericarditis often has pain as the outstanding symptom.

V. Pulmonary Pathology as a Source of Chest Pain

The lung parenchyma is usually considered insensitive and the parietal pleura is the chief site of pain transmission. Tension on the parietal pleura may result from its adhesion to the moving visceral pleura or to sudden change in intrathoracic pressure.

It is common for patients with well-advanced hypertrophic pulmonary emphysema to complain of sternal and parasternal pain, likely the result of pressure of the voluminous lung on the parietal pleura.

Other causes of acute chest pain are pulmonary embolism, spontaneous pneumothorax, pleuritis, bronchogenic carcinoma and atelectasis.

VI. Hematological Pathology as a Source of Chest Pain

Severe anemia can manifest itself by the patients chief complaint of precordial pain. Palpitation, tachycardia and apical systolic murmur usually co-exist and the pain may be due to coronary insufficiency. Correction of the anemia relieves the pain.

Sternal pain of a deep-seated boring type is not infrequently seen as the initial symptom in multiple myeloma.

VII. Bone, Muscle and Neurological Pathology as a Source of Chest Pain

Posterior root ganglionitis may evidence itself as acute chest pain and diagnosis may be quite confusing before the appearance of the eruption which is occasionally delayed for as long as three days.

In tabes dorsalis there may be hyperaesthesia and pain in the skin over the chest. The sensory involvement may develop before the characteristic neurological signs. Sensations of constriction about the waist and chest which follow involvement of radicular nerves occur.

"Growing pains" in children sometimes centre about the thoracic cage.

Cough fractures of ribs produce localized pain and tenderness and the chest x-ray readily demonstrates such etiology.

Osteomyelitis, tuberculous or staphylococcal, is a rare cause of chest pain.

Most cases of so-called intercostal neuralgia are now regarded as forms of non-articular rheumatism such as fibrositis or myositis.

Ankylosing spondylitis by diminishing thoracic expansion due to involvement of the costo-transverse and costo-vertebral joints, results commonly in a chest which feels stiff and tight and is marked by constant aching.

Travell and Rinzler have studied the role played by the voluntary muscles in pain syndromes of the chest and arm. They believe that coronary occlusion results in reflex spasm of the chest and arm muscles just as acute appendicitis or any form of the acute abdomen results in reflex rigidity of the abdominal musculature. Furthermore abnormal impulses from the heart may lead to the development of a self-perpetuating reflex which may be maintained for long periods of time by the skeletal muscles.

In addition, unless a positive diagnosis is made in the purely somatic pain syndrome resulting from fatigue and strain of voluntary muscles, in the absence of organic heart disease, the too-ready apprehension regarding the heart may lead to the perpetuation of the somatic pain cycle by prohibition of exercise and lack of normal use of the voluntary muscles. In these cases the enormous variation in disability from day to day leads to correct differentiation from true effort angina for example. Just as in intermittent claudication, the pain of angina appears after walking approximately the same distance within narrow limits from day to day, while that due to muscle disorder varies in disability over short periods of time.

Abolition of pain by blocking somatic trigger areas clinches the diagnosis.

Cervical arthritis and ruptured cervical intervertebral disc are occasional causes of pain simulating coronary disease.

VIII. Psychic Pathology as a Source of Chest Pain

It has been stated that "sixty per cent of cardiac patients who consult cardiac specialists are suffering from an exaggerated or wholly unnecessary anxiety about their heart arising from suggestion and not based on reason." A tell-tale point which makes diagnosis obvious is that these patients usually locate their complaint of pain precisely over that part of the thorax where the heart is commonly reputed to reside and not substernally where cardiac pain almost always localizes.

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Article

The National Health Service in Britain

A Comment Based on Personal Experience

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Canadian medical journals have published some fairly detailed reports on the National Health Service, as well as numerous opinions as to the merits of the "British experiment" which have been put forward during discussions about the future development of medical services in Canada. These have made interesting reading, but while it may be salutary to see ourselves as others see us, sometimes the picture is hard to recognize. Perhaps the combined effect of many criticisms may have been to create an unduly black impression in the minds of the many Canadian doctors who have not had the opportunity to see for themselves. Many may perhaps have concluded, like a past President of the Winnipeg Medical Society, that "... socialized medicine in Great Britain ... has produced an unhappy situation breeding discontent, especially among the rank and file of the profession. ... It has among other things disrupted considerably the principles of practice which constitute much of the attraction to those entering the profession."¹ It is rather remarkable, in view of this sweeping denunciation, that the scheme seems to be working.

Two especially comprehensive reports^{2, 3} by distinguished Canadian observers present very adequately the various viewpoints they encountered in Britain. But as seen from here both seem to place undue emphasis of the difficulties and the unfavorable opinions. There may be several reasons for this. A short visit does not make it possible to meet a fully representative sample of the people who are actually working in the service, or to explore all types of community. Some officials of the British Medical Association, who were exceedingly aware of the difficulties encountered in the developing service, may have tended to emphasize its doubtful features more than its advantages. And the scheme can not be judged objectively without taking into full account the type and standard of health services which had existed before. Even with these disadvantages in mind, it is hard to see why the experiences reported by one visitor should have led him to the sweeping conclusion that "... a State Medical Service cannot be other than ruinously costly, inefficient, and destructive of the warm personal relationship between the doctor and his patient which is conducive to good medical practice, and which is prized both by the public and by the profession."²

At a time when the profession in Canada is seeking an equitable way to provide the community

with medical care at reasonable cost and without lowering of standards, it would seem wise to study the British plan objectively, searching for features worthy of emulation as well as for pitfalls to be avoided. In the hope that a somewhat different viewpoint may help in this I venture to add yet another to the many comments on the changes brought about by the service.

While my experience has been confined to only one part of Britain, it now extends over nearly four years. I came from Manitoba to a University city in a rather uniquely compact area of Northern Scotland six months before the Health Service began, and have remained on the staff of the same group of hospitals ever since. It has been most interesting to observe the changes which have taken place during that time and to sense the reactions of the various groups of the profession. My interpretation of events must necessarily be influenced to some extent by personal experience and by my own ideas and may thus emphasize some aspects not perhaps so obvious to other observers with different experience and different opinions.

The General Practitioner and the Hospitals

Considerable misunderstanding has been caused by attempts to compare present-day British practice with medicine as practised in Canada. It is often inferred that the Health Service is to blame because in some ways the British standards are lower. But this is no new thing. It must be remembered that the system of medical practice has evolved in very different ways in Britain and in Canada. The relationship between the hospital and the general practitioner is a good example of this.

Most Canadian hospitals, like the communities they serve, are comparatively new by British standards. Usually they were started by general practitioners, and while they have grown rapidly they have continued to be used to the full by general practitioners for the care of private patients and very often of public ward patients as well. A close bond between the practitioner and the hospital has resulted, which in many ways is of benefit to both. The hospital has a close liaison with the whole profession; the doctor maintains a wide field of interest. But, particularly in specialized fields, the standard of care, within one hospital, may vary rather widely, reflecting the different abilities of individual doctors.

In Britain, general practitioners as a group have never had a particularly close association with the big hospitals. In most cities two distinct types of hospitals have developed, the voluntary hospitals and local government hospitals. Both have come to be largely staffed by specialists. A third group,

the small private hospitals and nursing homes for paying patients, have been shared to some extent between general practitioners and specialists.

The voluntary hospitals began as philanthropic institutions. Some are centuries old and have acquired strong individual traditions. Many of them provide highly specialized consultant services with both out-patient clinics and wards, often associated with medical schools. Particularly in the larger ones, appointment to the senior staff involves a prolonged period of training and a highly competitive process of selection. General practitioners, who could seldom aspire to staff appointments, have long been accustomed to sending their patients to hospital for specialized care and have mostly confined their own work to what can be done outside hospital. In most of the nursing homes for paying patients the same division of responsibility between the referring practitioner and the specialist has been the custom.

Other British hospitals have come up the hard way, through evolution from work-houses and "Poor-Law Institutions." These were provided by local governmental bodies for the care of the poor. In some districts they have been developed into highly efficient hospitals, but many still show the marks of their humble origin. Here also the general practitioner has hitherto had little to do with the care of his patients on the wards.

While it has always been theoretically possible for an able and ambitious general practitioner to work his way up to a staff appointment in either a voluntary or a local government hospital, the fact remains that very few did so. In some cities where there were many men with special training and experience some of them combined a certain amount of specialist work with general practice. They were not general practitioners first and specialists second, but primarily specialists who did general practice to make a living. If they established a reputation in their speciality they allowed their general practice to lapse. Even before the health service began the trend was toward a clearer division between general and specialist practice, and those who succeeded to hospital staff appointments were expected to withdraw from general work and to confine their private work to consulting.

It is, of course, highly debatable whether this division between practitioner and hospital is a good thing, or whether it should be allowed to develop in Canada. But if the planners of the British health service had attempted to break down the long-established distinction by throwing the hospitals open to general practitioners there would have been great confusion and the standard of hospital care would have been lowered. I doubt whether many of the general practitioners would have favoured such a step.

In smaller communities the gap has never been so wide. Many rural districts have small "cottage

hospitals" staffed by the local practitioners. In this region at least nothing has been done to disturb this relationship, though the health service provides visiting consultants who can broaden the scope of the work done in the smaller hospitals.

General Practice

The general practitioner's standard of work and his facilities are very poor in many places in Britain. Partly this is a result of the system under which a doctor can, and sometimes does, spend a whole lifetime in practice without going inside a hospital other than as a medical student. Even more it is a reflection of the social conditions in the individual doctor's district. Formerly a doctor in a wealthy residential district could make a good living with comparatively few patients, giving adequate attention to each. In depressed industrial areas the income per patient was so small, whether by private payment or under the old "panel" system that in order to make a living a doctor had to try to care for huge numbers of patients and deal with them by mass-production methods. Often this meant that the doctor became a mere filter through which the more seriously ill patients passed to out-patient clinics. This type of work, combined with the uninspiring social and intellectual environment which went with it, could not do otherwise than force a doctor's standard down, and the more able or ambitious individuals tended to leave such practices while the residue remained. In this country of large and concentrated population comparatively few practices, in the cities at least, contained the two elements of rich and poor by means of which the classically altruistic family doctor maintained both his social position and his professional ability.

The report on "General Practice in England Today," by Dr. Joseph S. Collings¹ vividly demonstrated the contrast between the best and the worst conditions, and aroused a spate of concern mingled with indignation on the part of profession and public alike. Both in Britain and abroad, attempts were made to place the blame for the deficiencies of general practice on the health service. In fact, as Dr. Collings was most careful to point out, the circumstances to which he drew attention had resulted from trends extending over several generations during which general practice had been adapting itself to changing cultural and professional patterns. The only sound criticism of the health service in this connection is that by adopting (at the insistence of the British Medical Association) the system of payment by capitation fee, it has encouraged general practitioners to take on larger numbers of patients than they can cope with, and at the same time it has so far given little direct aid toward providing better equipment or working conditions.

I have no personal experience of the problems of general practice under the scheme, but in talking with my general practitioner friends I find

that they mostly seem fairly well satisfied in principle and only critical of details. It would, I think, be a mistake to judge the attitude of most practitioners by the fulminations of the few who write hate letters to the British Medical Journal.

Doctors with upper-class practices and comparatively few patients have taken a considerable loss, since not many patients in these days of rising costs feel disposed to pay private fees when they are already contributing to a public medical service. On the other hand, practitioners in industrial and generally under-doctored areas are better off financially under the health service, and could afford to reduce their numbers of patients a bit without losing income if they were prepared to do so. But the rising cost of living, especially in the cities, is encouraging doctors to keep on the largest possible number of patients and this keeps down the standard of their work. Country doctors are usually better off, and can get by with fewer patients and do better work. In addition to the capitation fees, they get a substantial grant for travelling expenses, and they may if they wish draw an additional 6/6 per patient per year for dispensing. Under this arrangement they provide any of the usual drugs which may be necessary, but they can claim for repayment of the exact cost of certain more expensive items such as the antibiotics. The better type of country practitioner, as well as feeling that he is adequately paid, believes in the principles of the health service since he can now give his services where the need is greatest rather than having to allot to his poorer patients the time left over after he had made a living from those who could afford fees.

Entry into general practice is still difficult. No thinking person really regrets the abolition of buying and selling the goodwill of practices, which weighted the scale heavily in favour of those who had means, irrespective of their professional ability. But the same feature of the capitation method of payment which tends to encourage the maintenance of large lists also makes it more profitable to employ a succession of junior assistants than to take a full partner. So the jump from assistant to partner or principal in a practice is made more difficult. The selection of candidates for vacant practices is in the hands of a committee of local medical men, who conceivably might not always be completely disinterested. And there is no doubt that it is more difficult to get into general practice from even a fairly senior hospital job than it is for a man who has by-passed hospital training and gone from graduation straight into assistantships.

On the other hand, a recent graduate starting into general practice is now in a much more secure financial position than formerly. Under the old conditions an assistant might be induced to work for years for a very low salary by the prospect of a possible partnership or succession in the practice.

Now there is a definite minimum salary starting at £700 per year with a prescribed annual car allowance. Superannuation begins to accumulate from the first, and is calculated at the time of retirement from the individual's average annual earnings throughout his period of service in the health scheme.

It is sometimes said that the expanding hospital services are taking away all that was best in general practice, and turning the practitioner into a mere distribution agency. I do not believe that this is true as far as the good practitioner is concerned. He no longer has to be content with giving his patients second-best service out of consideration for their pocket-books. Formerly doctors often not only gave their services free, but had to provide drugs as well; or, if the patient could afford a little, they often felt obliged to prescribe the cheapest but not necessarily the most effective medication. Now the practitioner can treat the patient's illness as it should be treated and has the satisfaction of knowing that he is practising better medicine. He can arrange specialist care in or out of hospital for anyone who needs it regardless of their means; he can have a consultant see the patient with him in the home, if he thinks it necessary, and the expense is borne by the service. The family doctor can now command for all his patients facilities which formerly only the rich could afford. As an example of this, some months ago the Professor of Obstetrics in Aberdeen was flown to Orkney by special plane to deal with a case of ruptured uterus in the local hospital.

With freer access to specialist services the general practitioner does not have to deal with problems for which he may not feel competent, such as grossly abnormal obstetrics, but the decision as to which cases to refer and when to refer them depends entirely on his own judgment. (With regard to obstetrics, the Scottish scheme is somewhat more elastic than the English one, which involves some restrictions on practitioners who have not had special training or experience in midwifery.)

In this part of the country the standard of general practice is very good. As far as I can judge from the type of case referred to the hospitals or out-patient clinics the practitioners have not become slipshod or disinterested in their selection of patients needing specialized care. A small minority pass the buck to the hospitals, as they did before, but these are mainly the harassed and overworked people with large working-class practices. The competent doctors appreciate the added facilities they now have at their command and use them with discrimination.

While general practice outside the hospitals restricts the practitioner's opportunity to apply specialized techniques, this may not be entirely a bad thing. The doctor does not have the worry of undertaking jobs for which he is not specially

trained, and he has greater opportunities, if he will take them, of getting to know the problems of his patients in their homes and their work. Far from being "just a G.P." he can become a specialist in practical Social Medicine; a guide, philosopher and friend of far more value to his patients than a person more pre-occupied with technicalities might be. A general practitioner⁵ who has recently reviewed the scope of his type of work considers that its most important components should be:

The extremes of life — childhood and old age.

Domiciliary midwifery.

Social medicine: (a) environmental, (b) industrial.

Infectious diseases.

The beginnings of disease processes, with special reference to the early diagnosis of (a) acute disease requiring early surgical intervention, and (b) malignant disease.

The domiciliary treatment of the closing stages of malignant disease.

The long-continued treatment of the chronic disabling diseases which seldom enter hospital.

The giving of advice and guidance on a host of problems, personal and marital, entering into the whole range of human relationships.

The adjudication of employability.

Certification: (a) National Health Service, (b) other.

Medical ethics.

It is not entirely disadvantageous for the patient to pass into the hands of the specialist when necessary. Those who lament the passing of the good old family doctor who did everything are seldom averse to seeing a specialist themselves if they need an operation, or are going to have a baby, or develop pneumonia or a psychoneurosis. There seems no reason to believe that the ordinary patient should feel differently.

It has been said that the general practitioner nowadays has to waste a great deal of his time filling in forms of various kinds. Some of these we hope will not be permanent, such as the ones authorizing special consideration for certain types of patient in a country where rationing is still necessary. It is surely not too much to expect that brief notes of each patient's progress and treatment should be kept, though there is some opposition even to this. I am quite certain that the British practitioner spends far less time in form-filling, including keeping his medical records, than his Canadian counterpart devotes to keeping his accounts and sending out bills.

I do not think that there can be many people who really believe that the exchange of money (or the incurring of debt) is an essential component of the doctor-patient relationship, yet this insult to the Hippocratic tradition is now almost a standard argument against "socialized medicine." Nor is there any real evidence that the imposition of a token payment would magically eliminate all but "genuine" cases of illness from the doctor's waiting-room. It might work the other way. Under the old "panel" system only the wage-earner of the family was entitled to free care; the wife and children had to pay. In some poor districts children suffered and some died because parents were loth to call in the doctor when they could not afford to pay for his services. Most practitioners

are now finding that their patients are still decent people who consult them because of real need and who are grateful for their care. More people attended their doctors after the scheme came in, but while a few were importunate or merely curious the majority really needed medical help which they could not afford before.

Much criticism of the scheme has been based on alleged abuses of its privileges, but I have seen no statistical evidence of the proportion of unnecessary consultations, or sets of teeth, or pairs of spectacles. My own impression is that the former Minister of Health was correct in saying that the great demand for these services was a genuine indication of a need which had previously not been met. Certainly nobody who had seen the high proportion of neglected mouths among even a comparatively select group such as members of the British armed forces could have any doubt of the need for huge numbers of dentures. One has only to remember the pitiable old people trying on spectacles in Woolworth's to realize the great need there was for proper ophthalmic services.

Those who advocate a "token payment" for all medical services seem to consider that it would solve the problem of the patient who seeks unnecessary attention. This attitude seems to be based on the assumption that there should be one law for the poor and another for the rich. While the neurotic or demanding or inconsiderate health-service patient is rightly condemned as a time-waster, no such criticism is heard of the paying patient who can often divert still more of his doctor's time and skill from productive application. It might be inferred that some members of the profession believe that psychosomatic medicine should be restricted to those able to pay for it.

The Hospital Services

The unsatisfactory conditions found in some British hospitals have often been selected for criticism. This is another legacy which the Health Service has inherited from the system (or lack of system) which went before. In more progressive areas there were good hospital services, evolved partly by voluntary organizations and partly by local authorities. In some other places, usually the depressed industrial communities where the need is greatest but the money is scarcest, the hospitals have never been nearly adequate, and as a correlate of this the standard of both general practice and the specialities in these areas has been shockingly low. In a recently published study⁶ of social policy during the 1939-45 war, R. M. Titmuss has graphically described the terrible conditions found before the war in both voluntary and municipal hospitals in many parts of the country. When this situation was exposed by the stress of war-time needs it became clear that sweeping changes were inevitable. Great improve-

ments were made in some areas under the Emergency Medical Service during the war, but much remained and still remains, to be done. The Health Service inherited all the hospitals as they stood—the good, the middling, and the simply atrocious. The original intention was to budget each year for a rapid expansion in the most needy districts, and very great improvements have already been made. But world conditions have interfered with the plans by causing sharp rises in the costs of building and equipment and maintenance, and by diverting government expenditure away from the building of hospitals toward the building of armaments. Under these circumstances it seems grossly unjustified to malign the service and its planners for a failure to clean up the mess completely and provide uniformly good facilities within three short years.

The country has been divided into a considerable number of regions for hospital administration. This area, the North-Eastern Region (Scotland), centres around the city of Aberdeen and covers Aberdeenshire, Moray, Banffshire and Kincardineshire, and also the counties of Orkney and Shetland. It is fairly compact and not too large, with a population of just under half a million mainly engaged in farming, fishing and light industry. There are no large concentrations of population, and few slum areas by comparison with some places farther south. The main hospital centre is Aberdeen city, where there is a famous university with a long-established tradition of medical teaching.

The hospital services were already fairly good before the advent of the health service. In Aberdeen itself there are two general hospitals, one originally voluntary, the other developed from a Poor-Law Institution and formerly administered by the Town Council. There are also a maternity hospital, a children's hospital, a hospital for infectious diseases, two institutions for the chronic ill, and two mental hospitals. Some of the towns in the surrounding areas have "cottage hospitals" staffed by the local general practitioners, and there are also some small rural hospitals for infectious diseases, or maternity, or chronic illnesses.

All the hospitals in the city are now available for teaching, and there is a close and cordial liaison with the university. Some clinicians hold full-time university appointments paid wholly by the university; they have full responsibility and privileges on the wards. Others who are employed by the hospitals take a full share of the teaching as well, and indeed their contracts state clearly that this is a part of their regular duties.

Broad policy for all hospitals in the region is decided by the Regional Hospital Board, which also deals with the financial administration of the government grants. More detailed administration of individual hospitals or groups of hospitals is delegated to separate Boards of Management; in the city there is one board for the general hos-

pitals, one for the special hospitals (maternity, isolation and children's) and one for the mental hospitals; in country districts the distribution is regional and each board is concerned with all types of small hospitals in its area. The general public, the profession, the local governments and the Department of Health for Scotland are represented on all these boards, and in the case of the teaching hospitals the University also. Within the limits of their financial grants, each board has almost complete autonomy.

The composition of the boards ensures that government representatives can not have undue authority, and the medical members represent the profession officially. In addition, each hospital Board of Management is advised by a committee representative of the entire permanent medical staff of the hospital, and the opinions and recommendations of this committee carry great weight. Decisions as to the "establishment" of specialists and trainee specialists of all grades in each hospital were made by the specialists themselves, and not by the boards of management or any administrative authority.

New appointments to the senior clinical posts on either hospital or university staffs are made on the recommendation of selection committees responsible to both. After the position has been advertised, this committee interviews applicants, and comes to a choice which cannot then be interfered with by any other authority. The selection committees have a preponderance of medical members and have the assistance of at least one independent expert advisor from outside the area, usually a very senior representative of the specialty with which the vacant appointment is concerned. It will be seen that there is no possibility of nepotism or political influence in such important professional matters—less than there may sometimes be where final selection is in the hands of a less responsible body.

In this area, as the hospital services were already fairly adequate, the health service has resulted in little increase in the number of beds. But there has been steady improvement in the amenities and equipment of many of the hospitals. One of the general hospitals was previously little used for teaching; now inequalities of staffing have been overcome and the standard of work and teaching facilities are equally good in both institutions. Some unnecessary duplication has been done away with by concentrating some of the more specialized departments, such as thoracic surgery, in one hospital only. The great lack, here, as elsewhere, is accommodation for the chronic ill. The Regional Hospital Board is responsible for the care of chronic patients who require institutional nursing and medical care. The Local Authority provides homes for old and infirm people who do not need such specialized attention. Serious deficiencies in both types of accommoda-

tion have resulted from the increased span of life, as well as from the very great shortage of houses and the need for many women of working-class families to take employment outside their homes.

Ambulance services have been expanded and are so planned that ambulances stationed at strategic points throughout the country can answer quickly any call from hospital, practitioner or police. From personal experience of many obstetric emergencies I have gained the greatest admiration for the swiftness, skill and kindness with which the ambulance men bring seriously ill patients to hospital from sometimes very inaccessible places. In Scotland, air ambulances are available to bring patients from the outer Hebrides, Shetland or Orkney to centres on the mainland. These also can be called for by the practitioner in charge of the patient.

In the out-patient clinic, senior specialists have been enabled to give more time to referred cases. An appointment system is being developed to minimize that bugbear of the traditional British out-patient clinic—the long queue patiently waiting on hard benches for their turn to be seen. More clerks have been employed to look after records and arrange appointments, and I suppose that these girls are included in the category of “top-heavy administration,” so often criticised. But they save the time of doctors and nurses, and of the patients too, who are dealt with much more expeditiously. Patients who are to be admitted for elective surgery or non-urgent investigation still comprise a fairly long waiting list. On the gynaecological ward the waiting time for repair of a prolapse not causing especially distressing symptoms has until recently been nearly a year, but the back-log is now being reduced steadily.

The system of hospital administration has worked well in this district, because it is relatively small and compact and the local problems and needs are fairly straightforward. I am told that the situation is not so satisfactory in some of the larger regions, where major decisions on policy may be made by regional boards too remote and too busy to understand the real needs of some of the communities within their districts. People who have been working for years to build up good hospital services for their own areas may see their plans apparently ruined by high-level decisions to build hospitals in neighbouring districts instead. Centralized administration does lessen the risk of undue influence by petty parochial politicians, but it may also discourage constructive local interest in local service. There will have to be more delegation of responsibility to the smaller boards of management, and there is some hope that this will happen. Some of the larger regions are at present just too unwieldy to be run efficiently. Another very cogent criticism is that the present system of financing prevents a hospital or

group of hospitals from applying money saved from one year's budget toward expansion in the next, and this can encourage precipitous and sometimes unwise spending. These faults in organization are being found out as experience grows, and will undoubtedly be corrected.

The Hospital Medical Staff

It is fair to say that the health service has very considerably changed the economics of specialist practice. Instead of rising through years of penury in jobs rich in experience but meagre in pay, toward the ultimate goal of affluent consulting practice, the embryo specialist gets a definite, reasonably adequate, and increasing wage right from graduation. Superannuation contributions accumulate from the first, and seniority brings a comfortable income, with an assured pension on retirement.

House surgeons (internes) start with an annual salary of £350 per annum, rising to £450 within two years; £100 a year is deducted by the hospital for board and lodging. After one or two years the majority branch off toward general practice, while a few elect to go on toward specialist training. These get posts as senior house surgeons at £675 going on to become registrars (the equivalent of senior residents in Canada) earning £780-£890, and then to senior registrars at £1000-£1300. By this stage they are usually ready to apply for full consultant status in the major specialties, and such appointments start at £1700 and work up to £2750 by age, responsibility and experience. There are intermediate pay scales for certain types of permanent hospital job which do not require such intensive and prolonged training. There is no less competition all along the specialist ladder than there used to be, but the trainee can now earn as he learns, and as a result the process of selection now depends on professional ability rather than the possession of personal means.

There has been a certain amount of difficulty about registrar appointments, which is gradually being straightened out. In many hospitals, especially in England, a large number of these posts were created when the health service came in, partly to accommodate young doctors coming back from the armed forces and partly to cope with the rapid expansion of work which was anticipated. Many of these appointments were not really suitable for specialist training; registrar scales of pay were offered to attract people to second class jobs. It soon became evident that the ladder of specialist training was becoming far too crowded for the comparatively small number of consultant posts available at the top, and it was necessary to reduce the number of registrars and to downgrade the jobs which were not up to standard. At the time this entailed a good deal of disappointment to some who had thought they were well on the way to becoming consultants.

But the effect has been to increase the competition for a smaller number of better jobs, thus ensuring that those who do make the grade emerge fully equipped for the responsibilities of a senior position. There are inevitably some who fall by the wayside, though the selection is mostly below the senior registrar level, but this is not a waste since those who can not complete full specialist training still have the valuable advantage of extra hospital experience if they enter general practice.

Consultants may elect to do hospital work only, on a full-time salaried basis. Or they may prefer to spend only a proportion of their time in the hospital service, the salary being commensurate, and be free to undertake private consulting practice as well. For a number of reasons the part-time appointments are more advantageous financially, if the community provides a sufficient number of paying patients. On the other hand, the full-time specialist usually has the opportunity to spend part of his life in investigation and teaching.

Perhaps my own position as a full-time member of the staff prejudices me, but there does not seem to be any lessening of interest or enthusiasm or ability among my colleagues since the scheme began. Of course there are doubts and grumbings and outbursts of irritation, but these are mostly provoked by the type of problem that is to be found in any hospital anywhere, and seldom arise from matters directly affecting professional prestige or the clinical work itself. I should judge that we work as hard as most of our Canadian counterparts and we certainly don't keep civil service hours.

Another point of satisfaction is that specialists very largely do specialist work. Normal obstetric cases, for instance, are either cared for by their own doctors outside the hospital, or if they are in hospital they are very competently looked after by medical students, midwives, house surgeons and registrars, always with adequate supervision. The senior staff may thus conserve their time and energy for emergencies and difficulties and have enough to spare for investigation and study and teaching. This is aided, too, by the sharing of duties, with days on call and days of more freedom. The personal relationship with the patient need not suffer, and patients with special problems, either obstetrical or emotional, are commonly followed through by one individual obstetrician. But one feels less continually restricted, knowing that no patient will lack skilled attention in emergency if her own obstetrician is not at hand.

The Patient's Point of View

I have not myself encountered many selfish or demanding patients, out to get their money's worth from the hospital service. Mainly, I have found patients from all strata of society pleasant, trust-

ing and appreciative, quick to understand the delays which the bed shortage may inevitably cause. They are coming to expect, and I think to get, more personal consideration and individual attention than was sometimes the case when the hospitals were primarily charity institutions. This can have only a beneficial effect on the standard of medical and nursing care.

With my wife and children I have experienced something of the receiving end of the scheme. We lodged our cards with a capable and thorough general practitioner who has seen us through numerous exanthemata. Our dentist, although he has an enormous working day, takes ample time to do work and is interested in preventive dentistry and patient with children. We do not have to wait longer for dental appointments than we did in Canada, and there is no delay in emergency. We have had a "Bevan baby," of quite as high a standard as the Canadian representatives. Three of us have been in hospital for one major and three minor operations and one blood transfusion. We have even had one refraction and a very satisfactory pair of "socialized spectacles." I am quite sure that our professional connection has not made the slightest difference to the standard of treatment and that any other family in this area would have fared as well.

The Problem of the Future

The National Health Service can only be understood against the background of history, and perhaps it is failure to appreciate this that leads many people from other countries to be so critical. The evolution of health services and of social services generally in Britain can be interpreted as a phase in the battle against the evil of the old Poor Laws, which enforced an unyielding distinction between the needs of the poor and of the rich. Dislike of the services provided under the old system arose not so much because of their meagre value as because of the impersonal, petty and often humiliating way in which they were doled out to the indigent. The bitterness aroused by the means test for unemployment benefit during the thirties was no new thing but merely another sign of a gradually increasing resentment against a service which treated the poor as a class apart.

The chief importance of the British experiment, therefore, arises from its basic principles rather than its detailed organization. It is the first nationwide attempt to provide medical, dental and hospital services to every member of the community, regardless of means, supported by compulsory insurance contributions paid by all except the disabled or those already dependant upon public assistance. The contributions are set so low as to be a real hardship to none, the cost of the service being met by the large number of individual contributions, with some aid from funds derived from

income tax and other sources of government revenue. In essence, it is a service supplied for the community by the community, not one supplied for the poor by the contributions of the rich, nor one voluntarily maintained by the provident section of the population for themselves. The principle which it involves marks an advance in social democratic organization beyond anything which had been tried before. But the principle is not only important for philosophical reasons. Any system which attempted to preserve the old barrier between rich and poor would have been completely unacceptable to the people of Britain at their present stage of social evolution and could not have succeeded.

At the present time, as a recent editorial in the *Lancet*⁷ points out, the basic implication of the service is threatened by inflation and rising costs. Even with rigid economy, it seems obvious that either the contributors must pay more, or the service must be curtailed, or a distinction must be drawn between those who can afford to pay for their care outside the scheme and those who cannot. This dilemma cannot be due to the principle of the community-wide service since exactly the same forces are working elsewhere. I gather that even in Canada, at the present time a country with a much wealthier population, inflation and rising costs are compelling the hospitals to seek voluntary donations even though most of their accounts are being fully paid through hospitalization insurance plans. At the same time the costs of insurance are rising and the organized profession is considering an official increase in the schedule of fees for medical services.

But even though the cause is world-wide, some immediate solution to the British problems must be found in Britain. Individual contributions can hardly be raised now, when costs have risen to the point where the average wage-earner has a struggle to provide his family with necessities. It would be a pity to narrow the scope of the service, although this has already begun in the imposition of moderate charges for false teeth and spectacles, because in its short life the health service has done much to raise standards of medical care especially among those whose need was greatest, and to abolish the average citizen's dread of financial catastrophe through illness. Perhaps the least real hardship would result from creating a distinction between those covered by the scheme and those more financially fortunate. But this would involve the application of a means test, always bitterly resented and never successful in a democratic state. Even more important, this step would mean abandoning the principle of a community-wide social service and would be considered a retrograde move in Britain today. No ultimately satisfactory solution is possible with-

out an easing of economic pressure throughout the world.

Conclusions Which May Arise From the British Experiment

I hope that I have made it clear that despite its many big problems and its need for improvement in many details the National Health Service is by no means the crack-brained and ill-planned fiasco that some of its detractors would have us believe. It would be temerity indeed for anyone on this side of the Atlantic—even a Canadian—to suggest that a similar plan would be practical or desirable in Canada. Just as the British scheme has evolved as an almost inevitable result of the historical background in this country and has been patterned to suit British needs, so any future health service in Canada will develop in a Canadian way to meet Canada's needs and will not and should not be a transplant from Britain. Accepting this, the pros and cons of the National Health Service can be assessed more objectively. But, however different the problem is in the two countries, experience of the British scheme may justify the suggestion of a few broad principles.

Firstly, no health service is likely to be permanently satisfactory which does not serve the whole community and draw contributions from all income groups. Exclusion of either the richest or the poorest would involve a means test, unworkable even when applied by a government and intolerable if imposed by a professional group or a business organization. If the wealthier classes have the option of not contributing to the service, a great many will remain completely outside it, and this can hardly fail to result in different standards of medical care for the scheme and the non-scheme patients. This is less likely to be the case when all people have the option of seeking their care privately but must nevertheless make their contribution to the scheme too. Exclusion of the wealthy would tend to raise the cost to the individual contributor in the rest of the community, pushing the price up beyond the means of the most poorly paid group. The care of these people would then be borne by someone else—either as a charity by the profession and the hospitals (perhaps introducing a third standard of care), or by the government paying their contributions for them. The second alternative again involves a means test. Also, by underwriting the costs of care for the poorer classes the government might find itself in times of depression protecting the medical organizations from sharing the economic vicissitudes of the rest of the community. That would be obviously unfair.

Secondly, if coverage is to be universal and contribution obligatory, no body other than the government has the right to work out the broad policy or the facilities to collect and distribute the

funds. The "consumers" of the service must have strong representation at high policy level, and whatever one's personal feeling may be about any given government at any given time, it would be hard to find in a democracy a better controlled and supervised administrative organization, subjected to constant publicity, continually criticized by the opposition, and having to justify itself to the electorate at frequent intervals. It would be quite unethical for any preponderantly professional organization to undertake to collect and administer the funds for a service which they themselves provide.

Fears of "government interference" in professional matters might be overcome if the scheme were to be administered by a sort of "para-governmental" organization using the funds collected by the government. Such a body could be made up of professional and lay members as well as representatives of the government, rather like the Saskatchewan Anti-Tuberculosis League on a much vaster scale. Safeguards would have to be developed against undue influence by pressure groups whether political or economic or even professional. Overtly autocratic behaviour on the part of the Ministry of Health has not been much in evidence here so far, and the organized profession is quite able to curb any such tendency. A system of checks and balances far more efficient than had been foreseen appears to be quietly evolving in practice. There seems to be less likelihood here of interference in professional matters by lay or political groups than has sometimes been the case in Canada.

Thirdly, I very much doubt whether it is practical to pay doctors and hospitals by fee-for-service. The dentists are paid in that way here, and while their earnings are limited only by their time and industry the paper work is a burden to the individual dentist and calls for a top-heavy administrative set-up. This is true even with a restricted specialty doing a comparatively standardized type of work. Consider the difficulty of recording, coding, classifying, checking, paying and auditing the multitude of small and large items under a full medical service with the accuracy which is obligatory in dealing with public funds. The cost of administration would soon overshadow that of the professional work. (Incidentally, despite the allegations of disproportionate costs of administration under the National Health Service, the Regional Hospital Board in this area used only 3 per cent of its gross expenditure for this purpose last year. I doubt if the necessary work could be done with much less). Under a system evolving such a multitude of detail the doctor's paper work would increase rather than decrease, leaving him still less time for his proper job.

The British experience has shown that payment by capitation is not without its drawbacks, chiefly

the temptation to take on more patients than can be served adequately. This is causing grave concern to the profession, which is trying to get around the difficulties by a complicated system of controlling regulations.

There is a hallowed tradition that payment by salary somehow demeans and degenerates a doctor. One has only to look about his professional colleagues to appreciate how untrue this can be. It may well be that the greatest single contribution our profession could make to a workable health service would be to design a fair and practical means of paying its members equitably according to their ability and industry. To infer that piece-work incentives are essential for a good standard of medical care is an insult to the profession, reducing it to the lowest level of crass commercialism. We must continue to look beyond considerations of prestige toward an understanding of our responsibility as a part of the greater community, to fulfil community needs without either dictating or being dictated to.

Summary

I have tried to set forth how the National Health Service in Britain looks to a Canadian who is working in it, contributing to it, and making use of its benefits for himself and his family. Advantages and drawbacks as I have come to know them are discussed.

While it would obviously be undesirable to try to transplant the British scheme, evolved to suit British needs, to Canada where the pattern of medical services has developed very differently, nevertheless Canadians should find that experience gained in the British experiment has positive as well as negative value. Members of the profession in Canada should not be satisfied with superficial criticisms of the National Health Service, but should insist upon unbiased and objective consideration of its basic principles as well as its detailed organization.

I am most grateful to my many colleagues, including general practitioners, members of hospital and university staffs and hospital administrators, who have given me the benefit of their knowledge and experience during the preparation of this paper. In general they have agreed with its contents, for which, however, I accept complete responsibility.

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Medico-Literary

J. C. Hossack, M.D., C.M. (Man.)

The Death of Herod

Thus the great and magnificent Herod lay, afflicted in body by the most painful and loathsome malady, tormented in mind by the ingratitude of his favourite son—perhaps with remorse for the murder of those of Mariamme. His last hours were still further embittered by the turbulence and disaffection of his subjects.

Among the innovations of Herod nothing offended the eyes of the zealous Jews more than a large golden eagle, which he had placed over the great gate of the Temple. Some daring and enthusiastic youths, instigated by two celebrated teachers, named Judas and Matthias, conspired to tear down the offensive emblem. On a rumour of Herod's death, they put their design in execution. Being apprehended, they boldly justified their conduct. Herod at first assumed something like moderation; he assembled the chiefs of the people, reproached them with the ungrateful return which they made for his munificence in rebuilding the Temple, which the Asmonean princes had left in decay; and only displaced Matthias, the High Priest, who was suspected of having encouraged the enterprise. The most criminal of the actual assailants and their teachers were burnt alive.

But now the disorder of the king made sensible progress; a slow fire seemed creeping through all his vital parts: he had a rabid appetite, which he dared not gratify on account of internal ulcers and dreadful pains, particularly in the colon. Dropsical symptoms appeared in his feet, which were swollen and exuded. Ulcers, which bred worms, preyed on the lower region of his belly and adjacent parts. His breathing was difficult; and violent spasms, which seemed to give him unnatural strength, convulsed his frame. He sought relief from the warm bituminous baths of Callirhoe, but returned to Jericho without improvement. There the frenzy of his malady working on the natural sternness of his disposition, he is said to have imagined a kind of testamentary cruelty, almost too horrible to be believed: he determined to extort a universal mourning for his death from the reluctant people. He commanded some of all the chief families in Judaea to be seized, shut up in the Hippodrome, and strictly enjoined his sister Salome that, immediately he expired, the guards should be let loose, and an unsparing massacre commence. Thus a wide, and general, and heartfelt wailing would

spread throughout all the land with the news of his death. But the dying requests of kings proverbially fail of their accomplishment, and, happily for human nature, this sanguinary injunction was disregarded.

Among these atrocities of the latter days of Herod, what is called the Massacre of the Innocents (which took place late in the year before, or early in the same year with, the death of Herod, four years before the vulgar aera of Christ) passed away unnoticed. The murder of a few children, in a small village near Jerusalem, would excite little sensation among such a succession of dreadful events, except among the immediate sufferers. The jealousy of Herod against any one who should be born as a King in Judaea—the dread that the high religious spirit of the people might be re-excited by the hope of a real Messiah—as well as the summary manner in which he endeavoured to rid himself of the object of his fears, are strictly in accordance with the relentlessness and decision of his character.

At length, just before his death, the ratification of the sentence against Antipater arrived from Rome. It found Herod in a paroxysm of torment so great that he had attempted to lay violent hands on himself. The rumour of his death induced Antipater to make a desperate attempt to bribe the keeper of his prison. This last offence was fatal. Herod just raised himself up in his bed to give the mandate for his execution, and then fell back—had only time once more to remodel his will; and thus, dispensing death on one hand, and kingdoms on the other, expired!

Milman, "History of the Jews."

"We Are Such Stuff—"

Manners impress as they indicate real power. A man who is sure of his point, carries a broad and contented expression, which everybody reads and you cannot rightly train one to an air and manner, except by making him the kind of man of whom that manner is the natural expression. Nature forever puts a premium on reality. What is done for effect is seen to be done for effect; what is done for love is felt to be done for love. A man inspires affection and honor because he was not lying in wait for these. The things of a man for which we visit him were done in the dark and cold. A little integrity is better than any career.—R. W. Emerson.

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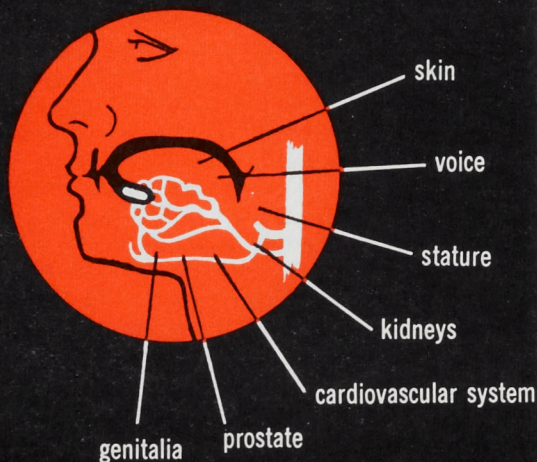
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Editorial

J. C. Hossack, M.D., C.M. (Man.), Editor



Happy New Year



By the time this reaches your eyes the sirens, whistles and other seasonal noise makers will have deaved themselves silent; and Scots the world over will meditate upon the blessings their race has conferred upon mankind. How tame, how stale, flat and uninteresting would be the New Year holiday were it to be stripped (as doubtless it is in Russia) of all its Scottish trimmings!

Now, lest anyone may think this is mere racial boasting, let us consider the peculiarly Scottish elements of this annual festival. First of all there is the matter of the flowing bowl. I grant you that the Ancient Saxons made much of their wassail—a poor “fashionless” sort of drink—but who, I ask you, first thought of “whusky?” Why a Scot of course! History fails to record the name of the inspired genius who first succeeded in pressing the spirit of John Barleycorn into the embrace of the peaty waters of highland streams—a divine combination such as would have warmed the cockles of Dionysius’ heart! ’Twas a sad omission on the part of history to leave him nameless but, then, who invented the wheel, and who was the true Prometheus that gave man fire?

To be sure whisky (Scotch whisky is always so spelled) has been flattered by imitation. But the “real McKay” (which, incidentally is properly applied to beer and not to whisky), the real thing, comes only from the Scottish glens.

Then there are the games which make the day pleasant and are suited to all climates. In temperate and warm regions there’s “gowf” commonly spelled “golf.” And where the winds bite shrewdly the “roarin’ game” entices young and old.

And then there’s “Auld Lang Syne”—I wish people wouldn’t persist in saying “Old” when they should say “Auld.” Can you imagine New Year’s Morn being ushered in to the strains of other words or other music?

Haggis has yet to become popular and in these peptulcerous times that is unlikely. And I must admit that on this occasion neither porridge nor bagpipes fit in abroad as properly as they do in the country of their origin. But even without these, enough remains to stamp the modern New Year celebration as more Scottish than anything else.

Perhaps their Empire might have lasted longer and been stronger had the Romans been able to conquer Scotland or Caledonia as they called it. Not that they didn’t try. Perhaps Gibbon was right when he said that for the preservation of their

wild independence the Caledonians “were not less indebted to their poverty than to their valour.” Yet the fact remains that “Their incursions were frequently repelled and chastised; but their country was never subdued. The masters of the fairest and most wealthy climates of the globe turned with contempt from gloomy hills assailed by the winter tempest, from lakes concealed in a blue mist, and from cold and lonely heaths, over which the deer of the forest were chased by a troop of naked barbarians.” So writes Gibbon who was a Sassenach and therefore, in matters relating to the Highlands, an ignorant sort of body; for all the time, in the glens and shrouded in the blue mist of mountain lakes, these “naked barbarians” were concocting a nectar, the fame whereof has spread over the whole globe, and devising pastimes which are more universally enjoyed than anything known to, or practiced by, the Romans.

So, when you next have occasion to sing “Auld Lang Syne” please say “Auld” and not “Old,” and, as you do so, give thanks to Robbie Burns who gave you the song, and to those nameless benefactors of the human race (naked barbarians, forsooth!) who in Scottish glens thought up haggis for meat, whisky for drink, and golf and curling for your recreation, to say nothing about the bagpipes for music! By combining them all you can be sure that at least the start of your New Year will be happy. Let’s hope the rest of it will be happy also!

The Other Side of the Picture

For a long time we have been reading and hearing about Britain’s National Health Scheme, and the impression gathered from all this is that the Scheme is bad. From the United States particularly come the gloomiest tales. There Socialism and Communism are twin devils—Siamese twins in fact—and the American is only too easily persuaded to see red even in the palest pink.

Now we have a chance to read a more balanced account of the Scheme’s workings. Dr. D. B. Stewart is living and practicing under the conditions of the plan. He bases his paper not on a few weeks’ “Cook’s Tour” but on daily experience with the scheme ever since its inception. Unlike some he has had experience with conditions of practice on both sides of the Atlantic. In other words he knows at first hand what he is writing about and knows it thoroughly—its strengths and its weaknesses, the good about it and the bad.

In his covering letter he says in part: “I have been increasingly distressed by the various criticisms of the British scheme which have appeared

particularly in the C.M.A.J. Not that I object to criticism, but the impression one gets from here is that the wrong points have been selected for castigation. Too many reports have been published based on insufficient study and strongly flavoured by preconceived ideas. It has become fashionable for every doctor who has to make a speech to interpolate a few disparaging remarks about the British system, the form having almost become so stereotyped that one can almost foretell the exact phrases which are used.

"As you will see, I have tried to be critical but in a fair way. The most important point to get across is that taking an hysterical attitude toward the British scheme in case a similar project should be started in Canada is quite unnecessary and also dangerous, since it can too easily encourage the 'last-ditch stand' mentality so blatantly evident in the U.S.A. I consider that an unbiased study of the British scheme could be of very great value with new arrangements for Canada are under consideration.

"I consider it to have been quite a privilege to have seen the N.H.S. develop right from the beginning. As you possibly know, I came to Aberdeen in January, 1948, with the idea of doing a year's work in Obstetrics. As luck would have it, I got my M.R.C.O.G. the following year, and became successively registrar and the senior registrar in the department. Last February a consultant appointment came vacant and I was lucky enough to get it, so I have had experience of most strata of the hospital hierarchy!"

We are very glad to publish this contribution. The fact that many of our readers know Dr. Stewart makes it more valuable, particularly when they remember his reliability and good balance.

The 1952 Convention

You may think this rather early to write about a Convention still ten months away; but we are already busy with our plans and we want to assure you that the meeting will be well worth looking forward to. What our plans are we don't mean to tell you at the moment. They will, however, satisfy you professionally and also from the stand point of entertainment.

It is about entertainment that we want to write now. You can assure yourself of a pleasant time if you will just let us know what you consider to be a pleasant time. Each one has his or her own ideas, and I add "her" because the Convention is even more of a respite for the wives than it is for their husbands.

So will you, ladies, send a note to Mrs. Alec Goodwin telling her what you would like to see or do? And, as you are probably more to be trusted than your husband in such matters, will you add

what he (grunting from behind his copy of the Review) would like to see or do?

Unless we are very much mistaken our Convention should attract so large a company that even musical, ballet or other such entertainments will not be unprofitable to the performers and therefore within possibility of presentation. Displays of handicrafts and even preliminary instruction in their techniques are likewise possible. Exhibition of your own hobby-work might well inspire others to do the same. Give us your ideas.

It has been a long time since any Class Reunion has been held. The Convention is an excellent time for such things. The class of '37, for example, has probably not met as a group since their Graduation Farewell. Every year is an anniversary for every class. Perhaps some of you to whom this idea appeals will let us know. The getting together of old classmates added to an excellent professional programme and pleasant entertainment would make the Convention an overwhelming success.

P.S.—As part of this is directed to the ladies, will you, doctor, let your wife have a chance to read it?

Accommodation at Banff

The Eighty-third Annual Meeting of the Canadian Medical Association will be held at Banff June 9th to 13th, 1952. The total accommodation of the Banff Springs Hotel and Chateau Lake Louise has been reserved for the members of the Canadian Medical Association, but the demand is so heavy that early reservation is desirable.

Members planning to attend should make application to Dr. A. E. Wilson, Chairman, Committee on Housing, 904 Greyhound Bldg., Calgary, using the Application for Accommodation printed in the November and subsequent issues of the Canadian Medical Association Journal.

Railway identification vouchers which permit members to take advantage of reduced railway fares may be obtained from the General Secretary, Canadian Medical Association, 135 St. Clair Ave. West, Toronto 5. Early reservation of sleeping car accommodation with local passenger agents is desirable to insure that the necessary rolling stock will be available.

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Book Reviews

Celiac Disease

The incidence of celiac disease is admittedly difficult to estimate. It has existed since ancient times as witness the comments upon it by Araeteus the Cappadocian; but its recognition in modern times began with a paper by S. J. Gee whose name (along with others) has been given to the disease.

The authors of this latest monograph upon the subject are of the opinion that the disorder is "actually far more common than earlier estimates would indicate. Increasing awareness of the condition as a specific disease has brought more frequent recognition of it. Also, more thorough understanding of varying degrees of its symptoms has revealed the existence of many mild cases, whereas the classical severe cases had been recognized formerly."

During the past twenty-five years the authors have seen, studied and treated 603 children in whom the diagnosis of celiac disease had been made. Their monograph is partly the result of the information gained during the observation and analysis of these cases. But, as one might almost expect, there has been a thorough ransacking of the literature from the first mention of the disorder. The book, therefore, is the most complete source of information on this ailment that has yet been published.

The 187 pages are divided into 19 chapters. These deal with every aspect of the condition. There is a discussion of etiology including a special final chapter headed "An Etiological Hypothesis." The symptoms, mental and physical, are considered as they affect, or are affected by, the functions of all the principal systems. There is a presentation of the pathological and radiographic findings.

Much attention is paid to the digestion and absorption of various food-stuffs—proteins, carbohydrates, fats, minerals and vitamins. In other words, the whole clinical picture is presented as fully as is possible in the present state of our knowledge.

Emphasis is laid on treatment, instructions for which are carefully detailed. A number of photographic illustrations is included, and among them are photos of two men in army uniform. As one of these wears the chevrons of a sergeant it is apparent that the treatment followed by the authors makes arduous and active life possible.

Management of Celiac Disease, by Sidney Valentine Haas, M.D., Professor of Pediatrics and Director of the Department, New York Polyclinic Medical School and Hospital; Consultant, Lebanon Hospital, Harlem Hospital, and Riverside Hospital for Contagious Diseases of the New York Health Department; Fellow of the New York Academy

of Medicine and Merrill Patterson Haas, M.D. 12 illustrations. J. B. Lippincott Company, Montreal. Price \$?????

Profession Pays Tribute to Dr. Moorhouse

Professor V. H. K. Moorhouse,
Suite 3,
492 Riverside Drive,
Toronto, Ont.

Dear Professor Moorhouse:

In view of your long and meritorious service to medical education in this Province the members of the Profession and of the Medical Faculty were invited to join in marking your retirement by a gesture to show their esteem for you. It was agreed that individual contributions should not exceed ten dollars. The inscribed silver cigarette box and enclosed cheque for \$1,000 therefore indicates the widespread regard in which you are held by your colleagues.

It gives me great personal pleasure to transmit this tribute to you and with it the sincere wishes of every one that you and Mrs. Moorhouse will enjoy many years of health and happiness.

Very sincerely

J. Doupe, M.D., Chairman,
Dept. of Physiology and
Medical Research.

November 26, 1951.

Professor J. Doupe,
Dept. of Physiology and Medical Research,
Winnipeg.
Dear Joe:

You people have got me in the state of the Irishman: "Not dead but spacheless."

The box from Birks arrived last week and your letter of Nov. 21, a day later with the cheque. The cigarette box is right in front of me as I write and I can only say it is beautiful and my wife and I are at a loss as to what to say.

Would you please try to convey to the Dean and Medical Faculty and to the Medical Profession in Manitoba the deep appreciation Mrs. Moorhouse and I feel about this generous gift and about the good wishes and kindly spirit that comes along with it.

Sincerely yours,

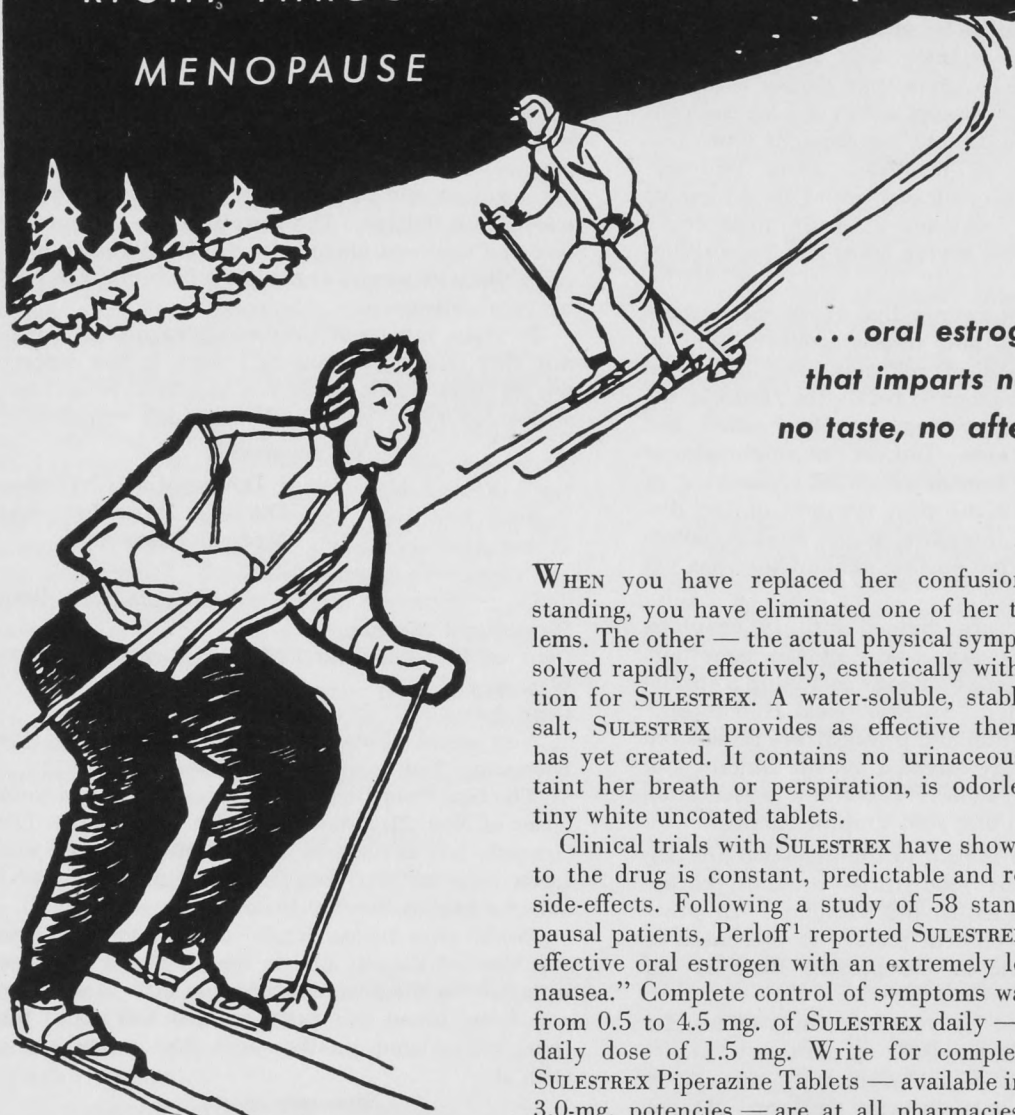
Victor H. K. Moorhouse.
November 21st, 1951.

Omission

In the November number we reviewed "Clinical Electrocardiography," by F. F. Rosenbaum and published by the Oxford University Press. The book is of 153 pages illustrated with a large number of tracings and completely up to date. We omitted to state the price which is \$5.50.

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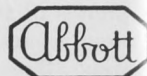


**... oral estrogen therapy
that imparts no odor,
no taste, no aftertaste**

WHEN you have replaced her confusion with understanding, you have eliminated one of her two major problems. The other — the actual physical symptoms — may be solved rapidly, effectively, esthetically with your prescription for SULESTREX. A water-soluble, stable, *pure* estrone salt, SULESTREX provides as effective therapy as science has yet created. It contains no urinoactive substances to taint her breath or perspiration, is odorless, tasteless, in tiny white uncoated tablets.

Clinical trials with SULESTREX have shown that response to the drug is constant, predictable and relatively free of side-effects. Following a study of 58 standardized menopausal patients, Perloff¹ reported SULESTREX a "potent and effective oral estrogen with an extremely low incidence of nausea." Complete control of symptoms was attained with from 0.5 to 4.5 mg. of SULESTREX daily — with a median daily dose of 1.5 mg. Write for complete information. SULESTREX Piperazine Tablets — available in 0.75-, 1.5- and 3.0-mg. potencies — are at all pharmacies.

ABBOTT LABORATORIES LIMITED, MONTREAL.



1. Perloff, Wm. H. (1951), Treatment of the Menopause. II. American J. Obst. & Gynec., 61:670, March.

Sulestrex

TRADE MARK

Piperazine Tablets

(PIPERAZINE ESTRONE SULFATE, ABBOTT)

Association Page

Reported by M. T. Macfarland, M.D.

Workmen's Compensation Board Fees

The last revision of W.C.B. fees was made in 1948 and came into force on October 1, 1948. The schedule adopted at that time was accepted voluntarily by the representatives of the Manitoba Medical Association.

At the annual meeting of the Association, in October, 1950, much dissatisfaction was expressed with fees paid for W.C.B. work and also with the regulations governing that work. A previously appointed negotiating committee under the Chairmanship of Dr. Henry Funk had had no success in its efforts to negotiate changes. The Association instructed the Executive to appoint a new Committee to reopen negotiations with the W.C.B. The new Committee consisted of Dr. P. H. McNulty as Chairman and Drs. C. M. Thomas (Portage la Prairie), C. B. Schoemperlen, C. H. A. Walton and R. W. Richardson, Chairman, Committee on Economics, as members.

The Committee received recommendations from various groups in the profession and after consideration of all the information at its disposal and all related questions produced a proposed new schedule. This schedule was carefully considered in detail and represented not only the opinions of the Committee but also reflected, as accurately as possible, the considered opinions of the profession as a whole. In addition the Committee prepared suggested changes in the regulations. The proposed new schedule and regulations was submitted to the W.C.B. on the ninth of June, 1951.

No action by the board was taken until a joint meeting of the board and the Negotiating Committee was held on the twenty-fifth of October. As a result of that meeting the board agreed to accept, in substance, the recommendations regarding the changes in the regulations.

On November the ninth the board informed the Executive Secretary, Dr. M. T. Macfarland, by letter, that it was prepared to make certain changes in the schedule. Herewith will be found a copy of the new regulations as agreed and a table of the 1948 fees with the new fees purposed by your Negotiating Committee and those proposed by the W.C.B.

It will be seen that of the 210 items listed in the 1948 schedule that your committee proposed changes in 156 items and that 53 be left unchanged. The board accepted only six of our proposals and made partial increases in another 26 items. In addition the committee proposed six new items (at present not listed) and of these three were accepted, two at an increased fee.

It will be noted that no mention is made of x-ray fees. The Negotiating Committee recommended that the schedule modified agreed upon previously between the board and the hospitals be adopted. In its formal reply of the ninth of November the Workmen's Compensation Board agreed to accept the recommended schedule but with a proviso that the fees be reduced by 25% when the x-ray work was done by any doctor other than a radiologist. While the Committee was gratified that the schedule was accepted it could not concur in the recommendation that difference be made between radiologists and other physicians. It is obvious that this would open up the whole problem on the differential between specialists and others with regard to all compensation fees.

The Negotiating Committee feels that the W.C.B. proposals are entirely inadequate and have so informed the board. It is, of course, the belief of the committee that it has the full support of the M.M.A. in this stand.

The W.C.B. advances as its main reasons for its small increases that other provinces have similar schedules and that Manitoba must not exceed these other provinces because such increased costs would put Manitoba employers at a disadvantage with their competitors, and further that an increase in medical fees would be inflationary.

Your committee did not feel that it could be bound by the usage in other provinces and indeed that it was probable that a similar argument was used in all provinces to keep W.C.B. medical fees low. With regard to the inflationary effect of increased fees the committee felt that doctors were living in a community which charged them full fees for non-medical service and that the profession could not be expected to make a unilateral sacrifice in an effort to curb inflation.

The cost of practice as well as living has risen enormously since 1948. The wages of labour have risen over 70% in that period and many other items have risen proportionately.

Doctors have never been expert at bargaining and for many years have accepted abnormally low fees for their services to the W.C.B. in a rather docile manner. Compensation Boards have acquired the habit of believing that doctors would continue to accept low rates of payment without too much fuss and perhaps only with ineffectual grumbling. The attitude almost seems to have been "take it or leave it."

As far as can be seen the board has no powers of compulsion other than the moral one that doctors never could refuse to treat the injured and undoubtedly they never would. However, this does

not mean that doctors must serve the injured workman through the compensation board although it is quite true that they might have difficulty collecting fees. It would be easy though unfortunate for the profession to refuse to co-operate with the board. But because doctors generally would regret such a distasteful course, it does not follow that they must accept an inadequate fee schedule.

The fee schedule is a contract made voluntarily

by the organized profession with the W.C.B. and the Negotiating Committee does not intend to agree with any proposal which it thinks is inequitable or unjust. The committee will try to be reasonable and continue to negotiate but the first concrete offer of the board is fantastically inadequate and cannot be accepted. The committee counts on, and needs, the solid support of all members of the Association.

C. H. A. W.

Table of Fees

Procedure	1948 Schedule W.C.B.	Proposed 1951 W.C.B. Schedule By M.M.A.	Proposed By W.C.B.
CALLS			
35. Initial consultation at home, office or hospital.....	\$3.00	\$4.00 2.00 (additional for 1st report)	\$3.50
36. Night (10:00 p.m. to 8:00 a.m.).....	5.00	5.00 (8 p.m. to 8 a.m.)	no change
37. Sundays and holidays.....	5.00	5.00	
SUBSEQUENT CALLS			
38. Home (where necessity shown).....	3.00	4.00	3.50
39. Office (where necessity shown).....	1.50	2.00	2.00
40. Hospital (where necessity shown).....	1.00	2.00	1.50
MINOR INJURIES			
41. Minor injuries—48 hours' care.....	3.00	4.00 (24 hours' care)	3.50 (48 hours' care)
42. Finger or toe dressings—after 48 hours' care—one digit.....	1.00	1.50 (after 24 hours' care)	1.50
43. Two or more digits.....	2.00	3.00	2.00
WOUND SUTURE			
44. Minor suture.....	3.00 to 5.00	3.00 to 5.00	
OPEN DRAINAGE			
45. Abscess—superficial.....	4.00	4.00	
INFILTRATIONS			
46. Infiltrations.....	3.00	3.00	
CONSULTATIONS			
47. For examination and written report.....	10.00		
With attendant on case.....		15.00	no change
Initiated by Board.....		25.00	no change
ASSISTANT'S FEES			
Additional to surgeon's fees where interns not available, necessity to be determined by Board.			
48. Where operation fee less than \$75.00.....	10.00	15.00 (less than \$80.00)	no change
49. Where operation fee is \$75.00 or over.....	15.00	20.00 (\$80.00 or over)	no change
ANAESTHETIC			
50. First half hour or part thereof.....	5.00	10.00	10.00 (first hour)
Subsequent half hour or part thereof.....		5.00	2.50 (subsequent quarter hour)
ASPIRATION			
51. Bladder.....	10.00	10.00	
52. Bursa.....	3.00	5.00	3.50
53. Joint.....	5.00	10.00	7.00
54. Abdomen or Chest—initial.....	10.00	15.00	no change
55. Abdomen or chest—subsequent.....	5.00	10.00	no change
56. Hydrocoele.....	4.00	5.00	5.00
57. Pericardium.....	20.00	25.00	25.00
LUMBAR PUNCTURE			
58. Lumbar Puncture—initial.....	10.00	15.00	no change
59. Lumbar Puncture—subsequent.....	5.00	5.00	no change
PLASTER CASTS (materials extra)			
60. Upper Limb.....	5.00	5.00	
61. Lower Limb.....	10.00	10.00	
62. Spica Jacket.....	20.00	20.00	
63. Body Jacket.....	15.00	15.00	

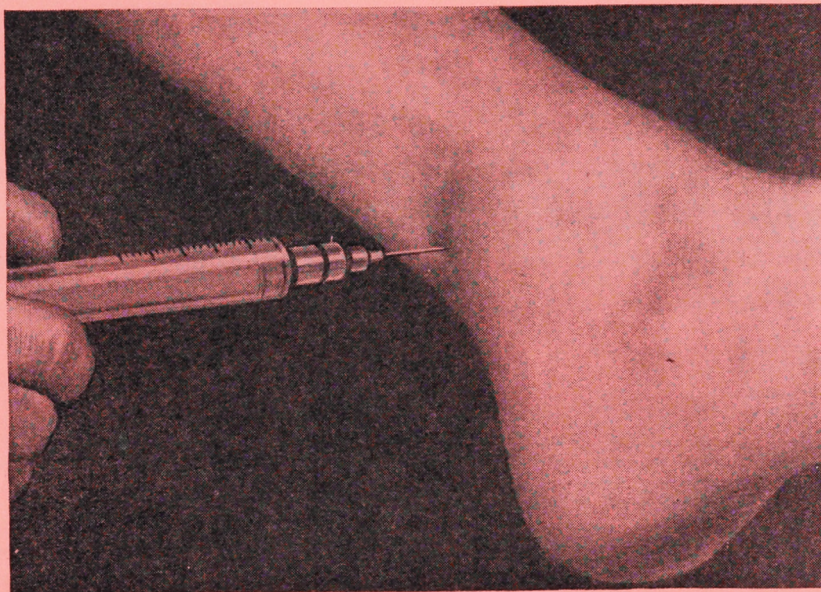
Procedure	1948 Schedule W.C.B.	Proposed 1951 W.C.B. Schedule By M.M.A.	Proposed By W.C.B.
SHOULDER			
64. Shoulder—Rotator cuff repair	125.00	150.00	
65. Infiltration of Shoulder, each	5.00	5.00	
66. Irrigation Subacromial Bursa	15.00	15.00	
SKIN GRAFT			
67. Skin Graft—to be assessed by Referee Board according to time, area and type of work.			
PLASTIC			
68. Plastic—to be assessed by Referee Board.			
BURSA REMOVAL			
69. Olecranon	35.00	35.00	
70. Prepatellar	35.00	35.00	
EPICONDYLITIS HUMERI			
71. Operative	35.00	35.00	
STENOSING TENOSYNOVITIS			
72. Operative	35.00	50.00	no change
Torn Calcaneo Fibular Ligament (sprained ankle)		25.00	no change
TENDONS			
73. Tendons—repairing of—fee governed by location, number and severity	15.00 - 100.00	20.00 - 150.00	to be assessed
74. Rupture Longhead Biceps	75.00	100.00	no change
75. Rupture tendo-Achilles	75.00	100.00	no change
76. Baseball finger—application of cast, including material	5.00	5.00	5.00
77. Trigger Thumb or Finger	25.00	(subsequent calls extra) 25.00	(subsequent calls extra)
DISLOCATIONS—Closed (Complications not covered)			
78. Clavicle, acromio-clavicular	20.00	25.00	no change
79. Shoulder	20.00	25.00	no change
80. Elbow	25.00	35.00	no change
81. Wrist—off radius	15.00	20.00	no change
82. Lunate	35.00	35.00	
83. Finger	5.00	5.00	
84. Thumb	10.00	10.00	
85. Hip	50.00	50.00	
86. Knee	50.00	50.00	
87. Toe	5.00	5.00	
88. Shoulder—recurrent dislocation, surgical repair	150.00	150.00	
AMPUTATIONS			
89. Finger—one	15.00	15.00	20.00
90. Finger—each additional	7.00	(subsequent calls extra) 10.00	no change
91. Toe—one	15.00	15.00	20.00
92. Toe—each additional	5.00	(subsequent calls extra) 10.00	(no extra calls) 7.00
93. Metacarpal—beveling 2nd and 5th	35.00	50.00	no change
94. Hand	65.00	75.00	no change
95. Foot	65.00	75.00	no change
96. Leg—below knee	65.00	100.00	75.00
97. Arm	65.00	100.00	75.00
98. Forearm	65.00	100.00	75.00
99. Thigh	100.00	125.00	no change
100. Disarticulation Shoulder or Hip	150.00	175.00	no change
EXCISION			
101. Head of Radius	75.00	75.00	
102. Knee Cartilage	85.00	115.00	no change
103. Hip	135.00	160.00	no change
104. Knee	100.00	125.00	no change
105. Ankle	100.00	125.00	no change
FRACTURES (Items 106-174)			
106. Chip or crack fractures not to be treated as fractures but paid for on basis of treatment required.			
107. Emergency treatment at neighborhood if referred	5.00 to 20.00	5.00 to 20.00	
SKULL AND FACE			
108. Malar—operative	25.00	35.00	no change
109. Mandible—open reduction	75.00	100.00	no change
110. Skull—operative	150.00	175.00	no change
SHOULDER AND RIBS			
111. Clavicle—non operative	25.00	35.00	no change
112. Clavicle—operative	75.00	85.00	no change
113. Scapula—body	25.00	30.00	no change
114. Scapula—neck	30.00	30.00	
115. Ribs	5.00 to 20.00	15.00	no change
116. Resection of rib or ribs	50.00	50.00	no change
		(subsequent care extra)	
UPPER EXTREMITY			
117. Finger (distal phalanx not as fracture)	10.00	15.00	no change
118. Each additional	5.00	5.00	
119. Metacarpal—non-operative	10.00 to 25.00	20.00	no change
		10.00	
120. Bennets fracture dislocation 1st, non-operative	35.00	(each additional) 40.00	no change
121. Carpal—one, except navicular	Basis care required		
122. Navicular	35.00	50.00	35.00 to 50.00
123. Removal of Lunate or Navicular	75.00	90.00	no change
124. Arthrodesis—Wrist	125.00	150.00	no change
125. Forearm—Radius, lower end	40.00	50.00	no change
126. Radius or Ulna—Shaft—non-operative	35.00	40.00	no change
127. Radius or Ulna—Shaft—operative	75.00 to 125.00	125.00	no change

Procedure	1948 Schedule W.C.B.	Proposed 1951 W.C.B. Schedule By M.M.A.	Proposed By W.C.B.
UPPER EXTREMITY (Continued)			
128. Radius and Ulna, Shaft—non-operative	60.00	65.00	no change
129. Radius and Ulna, Shaft—operative	100.00 to 150.00	150.00	no change
130. Head of Radius—non-operative, no displacement	20.00	25.00	no change
131. Head of Radius—non-operative with displacement	35.00	40.00	40.00
132. Head of Radius—operative	75.00	75.00	no change
133. Olecranon—non-operative	25.00	40.00	no change
134. Olecranon—removal	75.00	75.00	no change
135. Humerus—chipped epicondyle	Basis Care Required		
136. Shaft—non-operative	50.00	65.00	no change
137. Shaft—operative	125.00	150.00	no change
138. Surgical Neck—non-operative	50.00	65.00	no change
139. Surgical Neck—operative	125.00	150.00	no change
140. Supracondylar—non-operative	50.00	65.00	no change
141. Supracondylar—operative	125.00	150.00	no change
SPINE			
142. Vertebral Bodies—non-operative	75.00	85.00	no change
143. Transverse Processes—necessitating cast	40.00	40.00	no change
144. Pelvis—except coccyx, single and no displacement	50.00	60.00	no change
145. Coccyx—non-operative with displacement	15.00	15.00	no change
LOWER EXTREMITY			
146. Toe (distal phalanx not included)	10.00	15.00	no change
147. Toe, each additional	5.00	5.00	no change
148. Bones of foot—metatarsal—non-operative	10.00 to 25.00	20.00	no change
		10.00	
		(each additional)	
149. Calcaneus—simple—cast only	40.00	50.00	50.00
150. Calcaneus—comminuted (bed with traction)	75.00	100.00	85.00
151. Arthrodesis	125.00	150.00	no change
152. Talus—astragalus—simple	50.00	50.00	no change
153. Subtalar (subastragaloid)	125.00	125.00	no change
154. Triple Arthrodesis Foot	150.00	160.00	no change
155. Fibula—non-operative—shaft and head	25.00	35.00	no change
156. Lateral Malleolus	35.00	50.00	no change
157. Potts—both malleoli	75.00	100.00	no change
158. Medial Malleolus—non displacement	35.00	50.00	no change
159. Medial Malleolus—operative	75.00	100.00	no change
160. Tibia—shaft—non-operative	50.00	60.00	no change
161. Tibia—shaft—operative	125.00	150.00	no change
162. Tibia and Fibula—non-operative	75.00	100.00	no change
163. Tibia and Fibula—operative	125.00	150.00	no change
164. Tibia—Condyle—non-operative	40.00	50.00	no change
165. Patella—non-operative	25.00	50.00	no change
166. Patella—operative	75.00	100.00	no change
167. Femur—Condyle—non-operative	40.00	50.00	no change
168. Supracondylar—non-operative	75.00	100.00	no change
169. Shaft—non-operative—no displacement	75.00	100.00	no change
170. Shaft—non-operative—with displacement	100.00	125.00	no change
171. Shaft—operative	150.00	175.00	no change
172. Transtrochanteric—neck—non-operative	75.00	100.00	no change
173. Transtrochanteric—neck—operative	150.00	175.00	no change
174. Transtrochanteric—neck—traction	100.00	125.00	no change
SPINAL FUSION AND INTERVERTEBRAL DISC			
175. Spinal Fusion—separate procedure	150.00	175.00	no change
176. Intervertebral Disc	150.00	175.00	no change
Intervertebral Disc—with fusion		225.00	200.00
ARTHROTOMY			
177. Shoulder, Knee, Elbow, Hip or Ankle	75.00	115.00	no change
MANIPULATION			
178. Manipulation under general anaesthetic, pre and post operative care extra	10.00	15.00	no change
ARTHROPLASTY			
179. Knee, Hip, Elbow, Shoulder, Ankle	150.00	175.00	no change
SURGERY — GENERAL			
ABDOMEN			
180. Laparotomy for diagnosis	100.00	100.00	no change
181. Perforations, stomach and bowel	150.00	150.00	no change
182. Splenectomy	135.00	175.00	no change
183. Hernia—Operation for Radical Cure—single	80.00	100.00	no change
184. Hernia—Double—two procedures	125.00	150.00	no change
UROLOGICAL PROCEDURES			
185. Prostatic Massage and Smear	3.00	5.00	no change
186. Cystoscopy	15.00	25.00	no change
187. Cystoscopy with catheterization, ureters—dilate ureter	25.00	40.00	no change
188. Urethra—stricture dilation—each sitting	3.00	5.00	no change
189. Bladder—cystotomy	50.00	75.00	no change
190. Bladder—litholapaxy (lithotripsy)	60.00	100.00	no change

Procedure	1948 Schedule W.C.B.	Proposed 1951 W.C.B. Schedule By M.M.A.	Proposed By W.C.B.
KIDNEY			
191. Nephrectomy	125.00	175.00	no change
192. Nephrostomy	125.00	125.00	
193. Nephrolithotomy	125.00	150.00	no change
194. Pyelolithotomy	125.00	125.00	
195. Nephropexy	125.00	125.00	
196. Perinephric Abscess (drainage)	50.00	50.00 (after-treatment extra)	no change
SCROTUM			
197. Hydrocoele—radical cure	50.00	50.00	
EYE, EAR, NOSE AND THROAT			
198. Submucous Resection	75.00	100.00	no change
199. Removal of f.b. from eye or eyes, extra corneal	3.00	4.00	3.50
200. Removal of f.b. from eye or eyes, embedded in cornea	4.00	5.00	4.50
201. Intraocular (magnet only)	50.00	100.00	no change
202. Magnet with scleral incision	100.00	150.00	no change
203. Corneal Ulcer	3.00	5.00	3.50
204. Cataract Operation—extracapsular—intracapsular	100.00	150.00	no change
205. Iridectomy	60.00	75.00	no change
206. Needling (discission)	35.00	50.00	no change
207. Ocular Muscle Operation—1 muscle	75.00	75.00	
208. Ocular Muscle Operation—2 muscles	100.00	100.00	
209. Simple Refraction—manifest without drops	5.00	5.00	
210. Cyclopegic	10.00	10.00	
211. Complete Perimetric Examination, central and peripheral fields	5.00	10.00	no change
212. Complete ocular muscle balance examination in cases of diplopia following injury, Maddox rod, cover test, diplopia chart, ductions, etc.	5.00	5.00	
213. Excision of Tear Sac	50.00	60.00	no change
214. Retinal Detachment Operation	100.00	150.00	no change
215. Trephine	100.00	100.00	
216. Nose Fractured—non-operative	5.00	10.00	no change
217. Nose Fractured—operative	35.00	40.00	no change
218. Iridenceleisis	50.00	60.00	no change
219. Cycloidalysis	50.00	60.00	no change
220. Tests for Malingering	10.00	15.00	no change
221. Partial Keratectomies	50.00	50.00	no change
222. Conjunctivitis—initial consultation and treatment	3.00	4.00	3.50
223. Conjunctivitis—subsequent consultations, etc.	2.00	2.00	
224. Simple Evisceration	50.00	60.00	no change
225. Enucleation—simple—no implant	65.00	75.00	no change
226. Enucleation—with implant	85.00	100.00	no change
227. Ptosis operation—simple suture	50.00	70.00	no change
228. Resection of Muscle or Facial Graft	100.00	125.00	no change
229. Hospital Visits after initial care in cases not covered by block fee	1.50	2.00	no change
NEUROSURGICAL			
230. Pneumoencephalogram	35.00	50.00	no change
231. Ventriculogram	50.00	75.00	no change
232. Chronic Sub-dural Haematoma	150.00	175.00	no change
233. Extra Dural Haemorrhage	150.00	175.00	no change
234. Sympathectomy 1—cervical, dorsal unilateral	150.00	175.00	no change
235. Sympathectomy 2—lumbar, unilateral	150.00	175.00	no change
236. Sympathectomy—Bilateral	200.00	225.00	no change
237. Sympathetic Block	25.00	25.00	no change
DERMATOLOGIST			
(as requested by Board)			
238. Initial Examination, including report for diagnosis and designation of treat- ment	5.00	10.00	7.00
239. Subsequent Consultations—home	3.00	5.00	3.50
240. Subsequent Consultations—office	2.00	4.00	2.50
241. Subsequent Consultations—hospital	1.50	4.00	2.00
242. Patch Testing—per visit	5.00	5.00	
243. X-Ray Treatment	3.00	3.00	
NEW ITEMS			
Nerve Anastomosis	125.00		no change
Tendon Graft—Thumb and Index	125.00		
Tendon Graft—Other Fingers	100.00		
(This where the Sublimus and the graft is to profundus tendon)			
Skin Graft—Tip of Finger	20.00		25.00
Kuntscher Nail in Femur	150.00		
Unna's Boot Cast	5.00		7.50
Inter-group commissions not paid for, Consultations not paid where consultant takes over treatment.			

WYDASE IN OFFICE PRACTICE

Part of a series on its everyday uses



Treatment of Sprains

In the treatment of simple ankle sprains, Wydase added to procaine

1. facilitates adequate diffusion of anesthetic.
2. reduces the number of injections required and
3. promotes rapid absorption of edema fluid and blood from the site of injury.

Application of an elastic bandage maintains local pressure. Swelling subsides rapidly and early function is thus encouraged!

LYOPHILIZED

W Y D A S E

Hyaluronidase Wyeth

"The Spreading Factor" facilitates absorption of injected fluid . . . large clyses or small volumes of anesthetic or therapeutic solutions.

1 Britton, R. and Habif, D. V.: To be published.

JOHN WYETH & BROTHER (CANADA) LIMITED
WALKERVILLE ONTARIO

Social News

Reported by K. Borthwick-Leslie, M.D.

Due to that good picture last month some of these are a "hangover" from the December issue. Sorry if they are a bit late.

Congratulations to Dr. Boris Black on the honor won by his son Moishe in the recent competitive examinations at the Sorbonne. Mr. Black is a '51 graduate of the U. of M., majoring in French.

Welwyn, Sask., was the scene of the wedding, Oct. 30, of Muriel Overholt, to Dr. Lewis Ansley Cawsey, son of Mr. and Mrs. Cawsey, Vancouver. Mr. Hugo Ross, Weyburn, was the best man. Dr. and Mrs. Cawsey will reside in Winnipeg.

Dr. and Mrs. Walter Fox recently returned from a motor trip to Vancouver, Mrs. Fox's former home. Dr. Fox, who is at present associated with the Psychopathic Hospital, which may account for his ability to pick up "characters" tells me my big brother, Jack Borthwick, was his partner in a hectic golf game at Shaughnessy, and suggests that Jack, being the only solvent member of our family, probably lives on his golf winnings. Am sure glad some of us have time to golf. Thanks for the friendly greetings, Doctor. En route home the Fox family visited Dr. Bruce Best (48) in Portland, Oregon, where Dr. Best is doing P.G. work in surgery at the Mullinomak County Hospital.

Congratulations to Dr. Walter Alexander who recently was elected to Fellowship in the American Academy of Ophthalmology and Otolaryngology. Really goes so many places doing P.G. work, conventions, etc., that I seldom catch up to him, but his honor is, I believe, the most recent.

Dr. Joseph Brook (Man., '41) with Mrs. Brook and daughter, after being in practice in Beausejour for six years post R.C.A.M.C., is moving to Saskatoon where he will be associated with his brother, J. H. Brook (Man., '35). His new address will be 11 Canada Bldg., Saskatoon. The best of good wishes for the future, Doctor.

It was pleasant to renew acquaintance with Dr. Geo. Baldry, who with Mrs. Baldry and children free, spent Christmas with their mutual parents in town. George is located in Manchester, New Hampshire, but judging from the accent, must have at least driven through Boston.

Congratulations to Dr. Wm. T. Fyles who has been awarded a Research Fellowship in Medicine by the American College of Physicians. Dr. Fyles is at present resident house physician at the General. This is the first award of this type to a graduate of the University of Manitoba.

Dr. J. D. Adamson has been appointed Chairman and Member of the Advisory Commission under the Health Service Act, effective Oct. 1, 1951.

December 28, 1951, Lois Harkness became the bride of Dr. Oscar Domke, at Portage la Prairie. Following a wedding trip to the United States, the young couple will reside in Winnipeg. Dr. Domke is an interne at the Winnipeg General Hospital.

At Knox United Church, December 22, 1951, Joanne Shigeta was united in marriage to Dr. H. Sugiyama. The young couple will also reside in Winnipeg, as Dr. Sugiyama is also an interne at the General Hospital.

Welcome and all the best to our new arrivals: December 2—Dr. and Mrs. Geo. Waugh, Wildwood Park, announce the arrival of George Gregory, a brother for Mona and Barbara.

January 3, 1952—Dr. and Mrs. Colin Ferguson of 15 Sherman Road, Chestnut Hill 61, Massachusetts, announce the birth of a daughter.

December 11, 1951—Dr. and Mrs. G. Friesen, Pilot Mound, announce the birth of Marianne.

December 29, 1951—Dr. and Mrs. W. J. Hart announce the arrival of Stephanie Jill.

December 12, 1951—Dr. and Mrs. Doug Bracken are happy to announce the birth of Michael Wylie.

December 12, 1951—Dr. and Mrs. Stewart McKenty announce the birth of a son—as yet the name I do not know.

Dr. and Mrs. Lawrence Rabson and Dr. and Mrs. Paul Green left Jan. 10 for San Antonio, Texas, where the doctors will attend the International Medical Assembly. Following the meetings they will motor through the South on an extended winter holiday. How lucky can some people get?

The forgotten man when birth congratulations and New Year's presents are passed around has been remembered at Portage la Prairie.

Unlike most doctors who attend at births and must be content with a cigar from the proud father, Dr. George Fairfield, of Portage, will also receive recognition for his part at the birth of Portage's first 1952 baby.

No similar award was earmarked for the Winnipeg doctor in the "first baby" race.

The Portage doctor, who brought a seven-pound, 15-ounce daughter for Mr. and Mrs. Thomas H. Kitson, of 800 Saskatchewan Ave. West, into the world is to receive a free car wash and grease job from a Portage garage.

The young lady, who was born at 8 p.m. New Year's Day, and her parents will receive the usual assortment of gifts from local merchants.

COUGH CONTROL WITH

The expectorants in Scilexol E.B.S. increase the mobility of respiratory tract fluids, aiding in their elimination.



SCILEXOL

Coughing spasms can be controlled by giving Scilexol E.B.S. with the following sedatives.*

- | | | | | | | |
|------------------------------|---|---|---|---|---|-------------------|
| 1 Codeine | - | - | - | - | - | 1 gr. per ounce |
| 2 Methadon | - | - | - | - | - | 10 mg. per ounce |
| 3 Tincture Opium Camphorated | - | - | - | - | - | 80 min. per ounce |

*Narcotics Order Required

THE **E.B.S.** SHUTTLEWORTH CHEMICAL CO., LTD. TORONTO, CANADA

Representative: Mr. S. M. Fairclough, 542 Ingersoll Street, Winnipeg

Department of Health and Public Welfare Comparisons Communicable Diseases — Manitoba (Whites and Indians)

DISEASES	1951		1950		Total	
	Sept. 9 to Oct. 6, '51	Aug. 12 to Sept. 8, '51	Sept. 10 to Oct. 7, '50	Aug. 13 to Sept. 9, '50	Jan. 1 to Oct. 6, '51	Jan. 1 to Oct. 7, '50
Anterior Poliomyelitis	17	6	5	3	26	15
Chickenpox	66	40	70	37	1228	1106
Diphtheria	0	0	2	8	5	16
Diarrhoea and Enteritis, under 1 yr.	25	13	15	16	121	128
Diphtheria Carriers	0	0	3	0	1	3
Dysentery—Amoebic	0	0	0	0	0	2
Dysentery—Bacillary	0	3	11	7	23	125
Erysipelas	7	1	4	6	25	16
Encephalitis	0	0	1	1	2	2
Influenza	7	2	9	9	770	200
Measles	55	43	41	22	2800	207
Measles—German	0	4	0	0	38	31
Meningococcal Meningitis	5	3	2	0	30	15
Rumps	44	44	31	22	1124	313
Ophthalmia Neonatorum	0	2	1	0	2	2
Pneumonia—Lobar	11	11	15	15	210	188
Puerperal Fever	0	1	0	0	1	4
Scarlet Fever	70	79	58	21	1015	287
Septic Sore Throat	4	4	5	7	25	41
Smallpox	0	0	0	0	0	0
Tetanus	0	0	1	0	0	2
Trachoma	0	0	0	0	0	1
Tuberculosis	95	93	46	80	733	820
Typhoid Fever	0	0	0	0	2	3
Typhoid Paratyphoid	0	0	0	0	0	0
Typhoid Carriers	0	0	0	0	0	2
Undulant Fever	2	1	3	1	8	29
Whooping Cough	48	41	67	46	343	275
Gonorrhoea	117	105	131	141	962	996
Syphilis	22	7	13	8	126	183
Tularemia	0	0	0	0	0	5

Four-Week Period, September 9th to October 6th, 1951

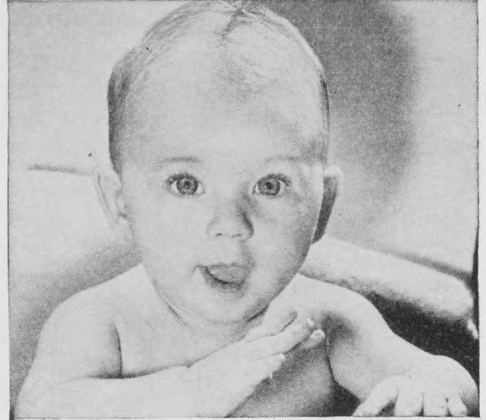
DISEASES	*779,000 Manitoba	*861,000 Saskatchewan	*3,825,000 Ontario	*2,952,000 Minnesota
(White Cases Only)				
*Approximate population.				
Anterior Poliomyelitis	17	24	488	150
Chickenpox	66	126	387	---
Diarrhoea and Enteritis, under 1 yr.	25	5	---	---
Diphtheria	---	---	2	1
Diphtheria Carriers	---	---	---	---
Dysentery—Amoebic	---	---	---	6
Bacillary	---	12	5	5
Encephalitis Epidemica	---	1	---	1
Erysipelas	7	---	---	---
Influenza	7	3	6	5
Measles, Infectious	---	---	8	---
Measles	55	40	163	23
German Measles	---	24	44	---
Meningitis Meningococcal	5	2	5	9
Rumps	44	68	324	---

Four-Week Period, September 9th to October 6th, 1951

DISEASES	*779,000 Manitoba	*861,000 Saskatchewan	*3,825,000 Ontario	*2,952,000 Minnesota
(White Cases Only)				
*Approximate population.				
Ophthal. Neonat.	---	---	---	---
Pneumonia, Lobar	11	---	---	---
Puerperal Fever	---	---	---	---
Scarlet Fever	70	60	78	29
Septic Sore Throat	4	3	---	15
Smallpox	---	---	---	---
Tetanus	---	1	---	---
Trachoma	---	---	---	---
Tularemia	---	---	---	---
Tuberculosis	95	50	66	184
Typhoid Fever	---	1	1	---
Typh. Para-Typhoid	---	---	1	1
Typhoid Carrier	---	---	---	---
Undulant Fever	2	1	9	7
Whooping Cough	48	92	229	16
Gonorrhoea	117	---	231	---
Syphilis	22	---	44	---



Baby A—2 weeks



Baby B—5½ months



Which baby would you put on meat?

ANSWER: BOTH! 2 to 3 months is common . . . and some physicians start at 2 weeks in formula!

Commonly meat is being fed at 2 to 3 months. In a recent survey among mothers feeding meat, the majority said their doctors recommended starting meat along with first solid foods!

Easy to feed in formula, too! Early meat feeding has come to mean starting meat in formula before other solid foods. Some physicians recommend two weeks—others one month.

HERE'S WHY: Ounce for ounce, no other infant

food provides more complete, high-quality proteins than Swift's Meats for Babies, at a time when the infant's requirement, expressed in terms of body weight, is at its height. Meat is also an excellent source of B vitamins and food iron.

Whatever age you recommend for starting baby on meat, when you recommend Swift's Meats for Babies you are sure of excellent quality, laboratory-controlled preparation and maximum retention of nutrients. Seven tempting varieties—beef, lamb, pork, veal, liver, heart and the new liver and bacon—all ready to serve at about half the cost of home-prepared meats.

Clinical studies show benefits of early meat feeding

To Prematures: Proteins, fats and minerals in Swift's Meats for Babies are as well tolerated, well digested and well utilized as those of milk by infants at this age: *Sisson, Emmel and Filer, "Meat in the Diet of Prematures," Pediatrics, 7, 89, (1951).*

At Six Weeks: Increasing protein intake 25% by the addition of Swift's Meats for Babies to formula promoted hemoglobin and red blood cell formation: *Leverson and Clark, "Meat in the Diet of Young Infants," J. Am. Med. Assn., 134, 1215, (1947).*

With Allergy Cases: A formula of Swift's Meats for Babies enriched with minerals, fat, and carbohydrate offers an effective milk substitute for infants allergic to milk proteins: *McQuarrie and Ziegler, "Nutritive Value of Mineral-Enriched Meat and Milk," Pediatrics, 5, 210, (1950).*

SWIFT CANADIAN CO., LIMITED

Only **SWIFT**
Meats for Babies



All nutritional statements made in this advertisement are accepted by the Council on Foods and Nutrition of the American Medical Association.

are all meat!

Department of Health and Public Welfare

Comparisons Communicable Diseases — Manitoba (Whites and Indians)

DISEASES	1951		1950		Total	
	Oct. 7 to Nov. 3, '51	Sept. 9 to Oct. 6, '51	Oct. 8 to Nov. 4, '50	Sept. 10 to Oct. 7, '50	Jan. 1 to Nov. 3, '51	Jan. 1 to Nov. 4, '50
Anterior Poliomyelitis	10	17	1	5	36	16
Chickenpox	112	66	170	70	1340	1276
Diphtheria	0	0	0	2	5	16
Diarrhoea and Enteritis, under 1 yr.	19	25	6	15	140	134
Diphtheria Carriers	0	0	0	3	1	3
Dysentery—Amoebic	0	0	0	0	0	2
Dysentery—Bacillary	1	0	3	11	24	128
Erysipelas	2	7	1	4	27	17
Encephalitis	2	0	0	1	4	2
Influenza	2	7	10	9	772	210
Measles	39	55	103	41	2839	310
Measles—German	3	0	4	0	41	35
Meningococcal Meningitis	3	5	2	2	33	17
Mumps	69	44	79	31	1193	392
Ophthalmia Neonatorum	0	0	0	1	2	2
Pneumonia—Lobar	16	11	13	15	226	201
Puerperal Fever	0	0	0	0	1	4
Scarlet Fever	105	70	64	58	1120	351
Septic Sore Throat	2	4	5	5	27	46
Smallpox	0	0	0	0	0	0
Tetanus	1	0	0	1	1	2
Trachoma	0	0	0	0	0	1
Tuberculosis	65	95	80	46	798	900
Typhoid Fever	1	0	1	0	3	4
Typhoid Paratyphoid	0	0	1	0	0	1
Typhoid Carriers	0	0	0	0	0	2
Undulant Fever	1	2	2	3	9	31
Whooping Cough	66	48	92	67	409	367
Gonorrhoea	90	117	128	131	1052	1124
Syphilis	8	22	11	13	134	194
Tularemia	0	0	0	0	0	5

Four-Week Period, October 7th to November 3rd, 1951

***DEATHS FROM REPORTABLE DISEASES**

For the Month of October, 1951

DISEASE (White Cases Only)	*779,000 Manitoba	*861,000 Saskatchewan	*3,825,000 †Ontario	*2,952,000 Minnesota
*Approximate population				
Anterior Poliomyelitis	10	11	184	105
Chickenpox	112	216	896	---
Diarrhoea and Enteritis, under 1 yr.	19	---	---	---
Diphtheria	---	---	---	10
Diphtheria Carriers	---	---	---	---
Dysentery—Amoebic	---	1	---	5
Bacillary	1	---	3	4
Encephalitis Epidemica	2	3	1	---
Erysipelas	2	2	1	---
Influenza	2	---	13	2
Jaundice, Infectious	---	---	8	---
Measles	39	43	261	26
German Measles	3	30	52	---
Malaria	---	---	---	4
Meningitis Meningococcal	3	---	6	7
Mumps	69	76	512	---
Ophthal. Neonat.	---	---	---	---
Pneumonia, Lobar	16	---	---	---
Puerperal Fever	---	---	---	---
Scarlet Fever	105	72	119	36
Septic Sore Throat	2	11	3	15
Smallpox	---	---	---	---
Tetanus	1	---	---	---
Trachoma	---	---	---	---
Tularemia	---	---	---	---
Tuberculosis	65	33	84	132
Typhoid Fever	1	2	2	---
Typh. Para-Typhoid	---	---	---	1
Typhoid Carrier	---	1	---	---
Undulant Fever	1	---	7	8
Whooping Cough	66	84	231	9
Gonorrhoea	90	---	209	---
Syphilis	8	---	46	---

Urban—Cancer, 53; Influenza, 1; Pneumonia, Lobar (490), 1; Pneumonias (other forms, 491-493), 7; Pneumonia of newborn, 1; Poliomyelitis, 2; Syphilis, 1; Tuberculosis, 8; Diarrhoea and Enteritis, 3; Septicaemia and Pyaemia, 1; Benign Neoplasms, 1; Neoplasms of Unspec. Nature, 1. Other deaths under 1 year, 21. Other deaths over 1 year, 223. Stillbirths, 14. Total, 258.

Rural—Cancer, 39; Influenza, 1; Pneumonia, Lobar (490), 2; Pneumonia (other forms, 491-493), 5; Pneumonia of newborn, 1; Tuberculosis, 7; Diarrhoea and Enteritis, 4; Septicaemia and Pyaemia, 1; Late effects of acute infectious Encephalitis, 1; Benign Neoplasms, 1. Other deaths under 1 year, 18. Other deaths over 1 year, 180. Stillbirths, 16. Total, 214.

Indians — Pneumonia, Lobar (490), 1; Pneumonia (other forms, 491-493), 3; Tuberculosis, 2. Other deaths under 1 year, 2. Other deaths over 1 year, 3. Total, 5.

*As reported to date.

Ortho is proud to announce . . .

the new simple effective method of control

Preceptin
VAGINAL GEL

used without a diaphragm

built on a new base

To replace the function of the diaphragm, a new and better physical barrier, incorporated into the Gel itself, was needed — one that could be depended on to cover the cervical os effectively. The new base of PRECEPTIN, achieved by blending recently developed synthetic gel-forming agents, meets this requirement, making it possible to do away with the diaphragm.

clinically proved

Of 3270 patients using
Preceptin Gel — 99.2 percent
received complete protection.

Preceptin's new base:

1. adheres well to the moist cervical mucosa — forms a persistent, adherent physico-chemical barrier over the cervical os.
2. is more miscible with semen — means greater spermicidal potency.
3. rapidly releases active spermicides — enables Preceptin to kill sperm on contact.



COMPOSITION: Preceptin contains the active spermicidal agents p-Diisobutylphenoxypolyethoxyethanol and ricinoleic acid in a synthetic base buffered at pH 4.5.

Ortho Pharmaceutical Corporation

(Canada) Limited — Toronto, Ontario

College of Physicians and Surgeons of Manitoba

Registration Committee

March 14, 1951

Interim Certificate Confirmed:

Durrand Everett Wallar, final year student, Queen's University.

Enabling Certificate Granted:

Shu Yun Tseng, B.M., National Central P., 1944.
Wei-Ping Loh, M.D., National Medical College, Shanghai, 1946; M.P.H., U. Mich., 1950.

Certificates of Registration Confirmed:

William Rupert Welply, M.R.C.S., England, 1935; L.R.C.P., London, 1935; F.R.C.S., England, 1945; M.B., B.S., U. London, 1946.

Isobel Davidson Moon, M.D., U. Toronto, 1945; L.M.C.C., 1945.

Victor Alan Rogers, M.B., Ch.B., U. Liverpool, 1939; L.M.C.C., 1949.

Douglas Willard Samuel Best, B.S., U. Toronto, 1939; M.D., U. Toronto, 1943; L.M.C.C., 1943.

Izchok Weisstub, M.D., U. Vienna, 1925; L.M.C.C., 1931.

Certificate of Registration Granted:

Richard Arthur Quine Lay, M.R.C.S., England, 1932; L.R.C.P., London, 1932; M.B., B.S., U. London, 1933.

Registration Committee

April 24, 1951.

Interim Certificate Confirmed:

Wilfred Napoleon Peter Albi, final year student, Ottawa University.

Enabling Certificates Confirmed:

Alwin Robert Parchment, B.A., Emmanuel Missionary College, Michigan, 1941; M.D., C.M.E., 1950.
Floyd Winfield Smith, M.D., C.M.E., 1936; D.N.B., 1936.

Alice Yakushavich, B.A., U. Man., 1945; M.D. C.M., McGill U., 1950.

John Philip Gofton, M.D., C.M., McGill U., 1950.

Enabling Certificate Issued:

Marian Turski, M.D., U. of Poznan, Poland, 1935.

Enabling Certificate Deferred:

Michel Stepan, M.D., Catholic U. of Louvain, Belgium, 1939.

Edgar Henri Joseph Voermanek, M.D., U. of Brussels, 1935.

Aimee Louise Wiggers, M.D., C.M., McGill U., 1950.

Certificate of Registration Confirmed:

John Buchanan Armstrong, M.D., U. of Toronto, 1943; L.M.C.C., 1943; Cert. Inter. Med.; F.R.C.P. (C), 1950.

Certificate of Registration Approved:

William Louis Henry Limmere Bell, M.R.C.S., Eng., 1930; L.R.C.P., Lond., 1930; D.P.H., R.C.P.S., Eng., 1938.

Certificate of Licence Confirmed:

Robert Keith Muir, M.D., C.M., Dalhousie U., 1931; L.M.C.C., 1931; Cert. Path. & Bact.

Certificate of Licence Approved:

James Elton Gilbert, M.R.C.S., Eng., 1941; L.R.C.P., Lond., 1941; D. Obst. R.C.O.G., 1949.

Executive Committee

April 30th, 1951

A meeting of the Executive Committee was held in the Medical Arts Club Rooms, at 1 pm., D.S.T., on Monday, April 30th, 1951.

Present: Dr. C. B. Stewart, chairman; Dr. J. S. Poole, Dr. B. D. Best, Dr. Ed. Johnson, Dr. C. H. A. Walton, and Dr. I. Pearlman, President; Dr. F. K. Purdie, Vice-President; Dr. T. H. Williams, Treasurer; Dr. M. T. Macfarland, Registrar, ex-officio.

The Chairman presented minutes of the Executive Committee meeting held January 31, 1951, copies of which had been forwarded to each member of Council.

Motion: "THAT the minutes of the Executive Committee meeting held January 31, 1951, be accepted as having been read." Carried.

1. Business Arising from Executive Meeting

January 31, 1951

A. Temporary Licence—Members of His Majesty's Permanent Forces and Dominion Government Employees

In accordance with Notice of Motion given at Council meeting, October 18, 1950, the following suggested by-law was prepared by the College solicitor:

1. Subject to such terms and conditions as it may see fit to impose, the Council may issue or authorize the issuance of a temporary licence to any person who is either:

(a) A member of His Majesty's permanent forces, including the Royal Canadian Navy, the Canadian Army (Active Force) and the Royal Canadian Air Force, who is stationed in Manitoba in connection with his duties as a member of those forces;

(b) An employee in a full time capacity in the public service of Canada who is stationed in Manitoba in connection with his duties as such; and who possesses the necessary qualifications for registration under the provisions of the Medical Act.

2. The temporary license shall remain in force and be of effect for such time as the council may determine; provided that a temporary license issued to an employee in a full time capacity in the public service of Canada shall be valid only during the first twelve months of such employment of the licensee in the public service; provided also that a temporary license issued to a member of His Majesty's permanent forces who is sta-

tioned in Manitoba in connection with his duties as a member of those forces shall remain in force and be of effect only for such time as the licensee is stationed in Manitoba in connection with his duties as a member of the permanent forces.

3. Each applicant for a temporary licence shall file with the Registrar:

- (a) Satisfactory evidence of his qualifications;
- (b) Satisfactory proof of his identity; and
- (c) A written request that the licence be issued, signed by,

- (i) The officer in command of the Medical Services of the branch of His Majesty's permanent forces in which the applicant is serving; or

- (ii) The head of the department of the public service of Canada in which the applicant is employed; as the case may be.

4. While the temporary licence remains in full force and effect the applicant shall pay the annual fee prescribed by Section 36 of The Medical Act.

5. A temporary licence shall entitle the holder thereof to practise medicine and surgery in the Province of Manitoba (subject to the terms and conditions prescribed therefor) while the said licence remains in full force and effect.

6. Every temporary licence shall terminate and be of no further effect, upon the discharge of the person so licensed from His Majesty's permanent forces; upon the person so licensed ceasing to be employed in the public service of Canada; upon the person so licensed ceasing to reside in the Province of Manitoba; upon the expiration of the licence; or upon the termination of the licence by the Council.

The solicitor's opinion was that while every person licensed by temporary licence must pay the annual fee collected from every member of the College, Council may prescribe whatever fee it may see fit to impose for the issuance of a temporary licence, and would appear that if the Council does not wish to impose any fee, it may refrain from doing so.

Motion: "THAT the Executive Committee accepts the proposed by-law prepared by the solicitor, applying to the Notice of Motion given at the October Council meeting concerning temporary licensing of members of His Majesty's Forces and Dominion Government employees." Carried.

B. Temporary Licence—Graduate Internes

The Registrar advised he had received no further word from the Chairman of the special committee appointed by the Associated Hospitals of Manitoba to study the problem of licensing graduate internes in hospitals.

C. Temporary Licence—Locum Tenens

In accordance with Notice of Motion given at Council meeting, October 18, 1950, the following suggested by-law was prepared by the College solicitor:

1. Subject to such terms and conditions as the Council may see fit to impose, the Council may issue and authorize the issuance of a Locum Tenens Licence to any person who possesses the necessary qualifications for registration under the provisions of the Medical Act, and who intends to serve as a Locum Tenens for any other physician.

2. The Locum Tenens Licence shall be valid only during the first three months of such service and shall not be renewable.

3. Each applicant for such a Licence shall file with the Registrar:

- (a) Satisfactory evidence of his qualifications;
- (b) Satisfactory proof of his identity;
- (c) Written request that the Licence be issued, signed by the physician for whom the Locum Tenens is being undertaken.

4. The applicant shall pay a fee of Ten Dollars (\$10.00), and while the Licence remains in full force and effect, shall also pay the annual fee prescribed by Section 36 of the Medical Act.

5. A Licence issued under this section shall entitle the holder thereof to practise medicine and surgery in the Province of Manitoba (subject to the terms and conditions prescribed therefor) while the said Licence remains in full force and effect.

6. Every Locum Tenens Licence shall terminate and be of no further effect, upon the person so licensed ceasing to reside in the Province of Manitoba; or upon the expiration of the Licence; or upon the termination of the Licence by the Council; or upon the termination of the service of the Locum Tenens.

The Registrar explained that the Executive Committee at their meeting on January 31, 1951, suggested that the temporary licence Locum Tenens should be valid for a period of twelve months rather than three.

Motion: "THAT the Executive Committee accept the proposed by-law prepared by the solicitor applying to the Notice of Motion given at the October Council meeting concerning temporary licensing of Locum Tenens, with the suggestion that the Licence be valid for a period of twelve months rather than three." Carried.

D. Legislation Committee—Specialist Register

Dr. J. S. Poole, Chairman of the Legislation Committee, advised that his Committee would meet on Wednesday, May 3rd. He presented a copy of a motion, which he and the Registrar had drawn up, to be presented to the Legislation Committee, and asked the Executive for any suggestions.

The Committee considered Dr. Poole's recommendation was very sound, and suggested that the final date on which no person may be registered as a specialist unless certified by the Royal College be set at January 1, 1954, in order that any doctor at present taking postgraduate training would be included.

E. Legislation Committee—Changes in Electoral Districts

Dr. Poole advised that this question would be discussed at the meeting of the Legislation Committee on May 3rd, and presented the suggested electoral districts for information. He stated that the districts were broken down by medical population, and instead of the City of Winnipeg having three electoral districts with two members each, it would be one district with six members. The Faculty of Medicine would still appoint two members, and the Council would still be composed of eighteen members.

F. Discipline Committee—Erasure of Dr. _____

The Registrar reported he had received no word from the Chairman of the Discipline Committee concerning a meeting to consider the erasure of Dr. _____.

G. Gordon Bell Memorial Trustees

The Treasurer reported he had attended a meeting of the Gordon Bell Memorial Trustees when it was decided to make a grant to a Manitoba graduate who is doing postgraduate work. He said an official notification would be forthcoming from the Chairman on his return to the city.

H. Cancer Institute

The Registrar advised a brief meeting of the Institute was held on January 5, 1951, for the purpose of accepting the Report of the Cancer Institute, which will be available in printed form for members of the profession.

I. Liaison Committee

The Executive Committee considered the position of the C.P. & S. in respect to the Registrar's salary, and the Chairman gave a report of an interview with Dr. Macfarland. Considerable discussion followed as to the stipend the College should pay the Registrar.

Motion: "THAT the Executive Committee recommends to Council that Dr. M. T. Macfarland's salary from the College be increased by Fifty Dollars (\$50.00) per month." Carried.

It was felt by the Executive that the whole question of the relationship with the M.M.A. in respect to the sharing of the office should be reviewed, with the object of obtaining some understanding of a regular charge made to the College by the M.M.A. The sharing of the purchase price of an addressograph machine was deferred.

J. Irregulars

The Registrar stated that at the meeting of the Executive Committee on January 31, 1951, he had been instructed to write the secretary of the Manitoba Chiropractors Association confirming the verbal conversations with him, and outlining the policy of this Executive. He said he had asked the solicitor to draft a suitable letter, but had not received it as yet.

K. Purchase of New Register

The Registrar presented a bill in the amount of Seventy-seven Dollars and Seventy-six Cents (\$77.76), being charges for two registers of two hundred and fifty (250) certificates each.

Motion: "THAT the account for Seventy-seven Dollars and Seventy-six Cents (\$77.76) for the payment of two registers containing 250 Certificates of Registration each, be approved." Carried.

2. Unfinished Business**A. Purchase of Bonds**

The Treasurer advised that as authorized by motion of Council on October 18, 1950, the Finance Committee had met and ordered the purchase of Four Thousand Dollars (\$4,000.00) in Dominion of Canada 3% registered bonds payable in 1966, from the Investment Account.

B. Appointment of Auditors

The Registrar advised he had communicated with the auditors, Price Waterhouse & Co., and obtained an estimate of One Hundred and Seventy-five Dollars (\$175.00) for auditing the books for the current year. He stated that since 1943 the charge had risen steadily from Forty Dollars (\$40.00), while in comparison the M.M.A. books have been audited for One Hundred Dollars (\$100.00) a year since 1944. It was suggested that a smaller Canadian firm might be willing to audit the books at a loss for the first year, if they were sure of having a good account for the future.

The Executive Committee agreed to leave the question of auditors in the hands of the Finance Committee, to bring a recommendation to the May Council meeting.

C. Reciprocity With Medical Council of Pakistan

The Registrar read an additional letter from the Secretary, Medical Council of Pakistan, advising that they would take up the question of reciprocity between the Pakistan Medical Council and the C.P. & S., Manitoba, on hearing from this College. The question of sponsorship of post-graduate courses has been referred to the Canadian Medical Association.

3. New Business**A. Estimate in Printing of Register**

The Registrar presented an estimate of Nine Dollars and Thirty-five Cents (\$9.35) per page for the register, plus 10% sales tax. He stated that the last register was printed in 1930.

Motion: "THAT the Registrar be authorized to have the register printed and order 1,000 copies." Carried.

B. Re Dates of May and October Council Meetings

Motion: "THAT the May meeting of Council be held at 2 p.m., D.S.T., on Wednesday, May 23rd, 1951." Carried.

Dr. Walton pointed out that the Senate of the University of Manitoba was not appointed until the middle of October, the College is not represented on the Senate for two meetings. He

inquired whether the appointment of a College representative to the University Senate could be handled at the May meeting instead of October.

The Executive agreed that this question should be discussed at the May meeting of Council, at which time the date of the Annual Meeting of Council will also be discussed.

C. Communication From Faculty of Medicine, University of Manitoba, Re Granting M.D. Degree Before Internship Year

The Registrar presented a letter from the Secretary of the Faculty of Medicine, University of Manitoba, advising that the Faculty had been reviewing the desirability of granting the M.D. degree at the end of the fourth year of medicine.

It was pointed out that Manitoba graduates were penalized by having to complete their internship before graduation. If the internship was after graduation, it would be considered as a postgraduate year by the Royal College of Physicians and Surgeons of Canada. The Department of Veteran's Affairs employee who graduated from another university and received his M.D. at the end of his fourth year, receives a higher salary than a Manitoba student who is employed as an under-graduate by Deer Lodge Hospital. According to our regulations it would not be possible for a Manitoba graduate to write his Medical Council examinations until he completes his internship year.

Motion: "THAT the Registrar communicate with the Dean of the Faculty of Medicine, University of Manitoba, inviting him to speak to the May meeting regarding the question of granting M.D. degree before internship year." Carried.

D. Request for Donation to Canadian Society of Radiological Technicians

The Registrar presented a communication from the General Committee Chairman of the Canadian Society of Radiological Technicians, advising their Ninth Annual Dominion Convention would be held in Winnipeg on September 12th, 13th, 14th and 15th, 1951, and requesting financial assistance.

Motion: "THAT the Canadian Society of Radiological Technicians be advised that we are unable to assist them, and that their letter be filed." Carried.

E. Communication from C.P. & S., B.C., Re Increase in Non-resident Fee

The Registrar presented a communication from the Registrar of the C.P. & S., B.C., advising that the Council were collecting a Twenty-five Dollar (\$25.00) fee for members who are practising outside the Province of British Columbia. The reason for this regulation is that a number of physicians obtained registration in British Columbia at the reduced fee of One Hundred dollars (\$100.00), and it was considered they should also help to contribute to the erection of the new Academy of Medicine Building.

F. Communication From C.P. & S., P.Q., Re Suggestions for Discussion at Meeting of Registrars in Montreal in June

The Registrar presented communication from the Registrar of the C.P. & S., P.Q., advising the meeting of the Registrars would probably be held on June 21st, and requesting subjects to be included on the agenda.

Motion: "THAT the Registrar be authorized to attend the meeting of the Registrars in Montreal in June at the expense of the College." Carried.

It was suggested that a matter for discussion would be on registration for the whole of Canada and the Registrar was instructed to advise members of Council, on the notice of the next meeting, that they should bring any topics for discussion at the Registrar's Meeting to the meeting of Council.

G. Request From Red Cross for Contribution

The Registrar advised he had received a copy of a mimeographed letter from the Red Cross requesting a contribution to their annual appeal for funds, and had replied that the College does not make contributions to public appeals, but that it would recommend itself to the general cause of the individual members.

Motion: "THAT the correspondence with the Red Cross be filed." Carried.

4. Business Arising from Minutes of Registration Committee, April 24, 1951

A. Re Increase in Fee for Enabling Certificate for Foreign Graduates

The Chairman of the Registration Committee, Dr. C. H. A. Walton, advised that applications for Enabling Certificates from graduates of European and Chinese universities were accompanied by reams of papers and documents which take a great deal of time on the part of the Registrar and the Registration Committee, and the fee of Five Dollars (\$5.00). He suggested that the fee should seriously be considered as inadequate. He pointed out that many of them come to the Province with no intention of practising here, but merely to obtain reciprocal registration with Great Britain. This College was simply rendering them a service. Dr. Walton inquired whether it would be the intention of the Committee to charge a higher fee for an Enabling Certificate for graduates who might be classified as foreign.

Dr. Walton was instructed to consult with the Registrar and bring in a Notice of Motion to the May Council Meeting.

Adjournment.

**Legislation Committee
May 2nd, 1951**

A meeting of the Legislation Committee was held in the Medical Arts Club Rooms, at 11 D.S.T., on Wednesday, May 2nd, 1951.

Present: Dr. J. S. Poole, Chairman; Dr. F. Purdie, Dr. A. L. Paine and Dr. I. Pearlman.

President; Dr. M. T. Macfarland, Registrar, ex-officio.

Re Specialist Register

The following motion was passed at the October Meeting of Council:

"THAT the Legislative Committee be requested to prepare a by-law for the purpose of setting up a specialist register."

The Legislative Committee recommends that a Specialists' Register be set up by the College of Physicians and Surgeons of Manitoba on the following basis:

The persons to be registered shall be:

1. Any person who is certified as a Specialist by the Royal College of Physicians and Surgeons of Canada.

2. Any person on a list of Specialists, prepared by a committee appointed for the purpose by the Council of the College of Physicians and Surgeons of Manitoba, including two representatives from the College of Physicians and Surgeons of Manitoba, two from the Faculty of Medicine, two from the Manitoba Medical Association, and two from the Manitoba Medical Service.

3. Until January 1st, 1954, any person may apply to the College of Physicians and Surgeons of Manitoba and ask to be registered as a specialist.

4. After January 1st, 1954, no person can be registered as a specialist unless certified by the Royal College.

Motion: "THAT the recommendation of the Legislation Committee concerning a Specialist Register be referred to Council." Carried.

The Registrar was requested to have the solicitor prepare a by-law.

Re Electoral Districts

The following motion was passed at the October Meeting of Council:

"THAT the Legislative Committee prepare a change in the Medical Act giving the Council power to fix the boundaries of the medical constituencies."

Suggested revision of Medical Act relating to Council, Medical Electoral Districts, Composition of Council, Term of Office, etc.

Section 4—There shall be a Council consisting of two members of the College chosen by the Faculty of Medicine of the University of Manitoba who shall be selected at a meeting thereof duly called for that purpose, and sixteen members of the College elected from the medical electoral districts established under this Act.

Section 5—The Province shall be divided into eleven medical districts, known as districts one to eleven, which shall respectively comprise the areas and elect members to Council as follows:

District Number One — 1 Member

That portion of Manitoba south of the fifty-third parallel and east of the Red River and Lake

Winnipeg, excepting the Elmwood portion of the City of Winnipeg, but including towns and villages therein.

City of St. Boniface

Alexander

R.M. Brokenhead—Beausejour T

R.M. de Salaberry—St. Pierre V

R.M. East Kildonan

R.M. East St. Paul

Emerson T

R.M. Franklin

R.M. Hanover—Steinbach T

R.M. LaBroquerie

R.M. Lac du Bonnet—Great Falls V

Lac du Bonnet V

R.M. Montcalm (East of Red River)

R.M. North Kildonan

Park

Piney

Reynolds

R.M. Ritchot (East of Red River)

R.M. Ste. Anne

R.M. St. Clements

R.M. St. Vital

R.M. Springfield—Garson V—Transcona T

Stuartburn

R.M. Tache

R.M. Victoria Beach

R.M. Whitemouth

District Number Two — 6 Members

City of Winnipeg including Elmwood

R.M. Assiniboia

Brooklands V

R.M. Charleswood

R.M. Fort Garry

R.M. Old Kildonan

R.M. St. James

Tuxedo T

R.M. West Kildonan

R.M. West St. Paul

Towns and Villages included therein.

District Number Three — 1 Member

Armstrong

R.M. Bifrost

R.M. Coldwell

R.M. Ericksdale

Fisher

R.M. Gimli—Gimli T

Grahamdale

R.M. Rockwood—Stonewall T—Teulon V

R.M. Rosser

R.M. St. Andrews—Dunnottar V—Selkirk T

Winnipeg Beach T

R.M. St. Francois Xavier

R.M. St. Laurent

R.M. Sigmund

R.M. Woodlands

Towns and Villages included therein.

District Number Four — 1 Member

City of Portage la Prairie

R.M. Cartier

R.M. Glenella

R.M. Lakeview

R.M. Langford—Neepawa T

R.M. Lansdowne

R.M. North Norfolk—MacGregor V

R.M. Portage la Prairie

R.M. Rosedale

R.M. Westbourne—Gladstone T

Towns and Villages included therein.

District Number Five — 1 Member

R.M. Dufferin—Carman T

R.M. Grey

R.M. Macdonald

R.M. Montcalm (West of Red River)

R.M. Morris—Morris T

R.M. Rhineland—Altona V—Gretna V
Plum Coulee V

R.M. Ritchot (West of Red River)

R.M. Roland

R.M. Stanley—Morden T—Winkler V

R.M. Thompson

Towns and Villages included therein.

District Number Six — 1 Member

R.M. Argyle

R.M. Lorne

R.M. Louise—Crystal City V
Pilot Mound V

R.M. North Cypress—Carberry T

R.M. Pembina—Manitou V

R.M. Roblin—Cartwright V

R.M. South Cypress—Glenboro V

R.M. South Norfolk—Treherne V

R.M. Strathcona—Ninette Sanatorium

R.M. Victoria

Towns and Villages included therein.

District Number Seven — 1 Member

City of Brandon

R.M. Cornwallis

R.M. Elton

Towns and Villages included therein.

District Number Eight — 1 Member

R.M. Albert

R.M. Arthur—Melita T

R.M. Brenda—Napinka V—Waskada V

R.M. Cameron—Hartney T

R.M. Edward

R.M. Glenwood—Souris T

R.M. Morton—Boissevain T

R.M. Oakland—Wawanesa V

R.M. Pipestone

R.M. Riverside

R.M. Sifton—Oak Lake T

R.M. Turtle Mountain—Killarney T

R.M. Whitehead

R.M. Whitewater

R.M. Winchester—Deloraine T

Towns and Villages included therein.

District Number Nine — 1 Member

R.M. Archie

R.M. Birtle—Birtle T—Foxwarren V

R.M. Blanshard

R.M. Boulton

R.M. Clanwilliam

R.M. Daly—Rivers T

R.M. Ellice—St. Lazare V

R.M. Harrison

R.M. Hamiota—Hamiota V

R.M. Miniota

R.M. Minto—Minnedosa T

R.M. Odanah

Park

R.M. Rossburn—Rossburn V

R.M. Russell—Binscarth V—Russell T

R.M. Saskatchewan—Rapid City T

R.M. Shoal Lake—Shoal Lake V

R.M. Shellmouth

R.M. Silver Creek

R.M. Strathclair

R.M. Wallace—Elkhorn V—Virden T

R.M. Woodworth

Towns and Villages included therein.

District Number Ten — 1 Member

That area south of the 53rd parallel including

Alonza

R.M. Dauphin—Dauphin T

R.M. Ethelbert—Ethelbert V

R.M. Gilbert Plains—Gilbert Plains V

R.M. Grandview—Grandview T

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R.M. Hillsburg

R.M. Lawrence

R.M. Minitonas—Bowsman V—Minitonas V

R.M. McCreary

R.M. Mossey River—Winnipegosis V
Mountain

R.M. Ochre River

Park

R.M. Ste. Rose—Ste. Rose du Lac V

R.M. Shell River—Roblin V

R.M. Swan River—Benito V—Swan River T

Towns and Villages included therein.

District Number Eleven — 1 MemberThat portion of Manitoba north of the 53th parallel
including:

Churchill

Consol

Flin Flon T

Lynn Lake

Norway House

Sherridon

Snow Lake

The Pas T

Towns and Villages included therein.

Section 9—An election for members of Council shall be held not later than one year following the passage of this Act on a date to

erked by Council. One member shall be chosen by the Faculty of Medicine for a term of two years and the other for a term of four years. Thereafter at each election one member shall be chosen for a term of four years.

At the first election members of the odd-numbered districts 1, 3, 5, 7, 9, 11, shall be elected for a term of two years, thereafter at each election for a term of four years.

At the first election three members of district number two shall be elected for a term of two years, and three members shall be elected for a term of four years. Thereafter at each election three members shall be elected for a term of four years.

Members of the even-numbered districts 4, 6, 8, 10, shall be elected at each election for a term of four years.

Changes in medical electoral districts and number of members of Council to be elected from each district may be made from time to time by a resolution of the Council passed by not less than two-thirds members of the Council present at a duly constituted meeting.

Motion: "THAT the recommendation of the Registration Committee concerning a change in the Medical Act to give the Council power to fix the boundaries of medical constituencies be referred to Council." Carried.

The Registrar was requested to obtain the Solicitor's opinion on the suggested change in the Medical Act.

Registration Committee

May 17, 1951

Enabling Certificates Granted:

Teodor Muczij, M.D., Karl's University, Prague, 1928.

Wolodymyr Bilynsky, M.D., University of Innsbruck, Austria, 1949.

(Peter) Lou Heng, M.D., l'Aurore University, Shanghai, 1941.

Ladislaus Bader, M.D., University of Prague, 1931; M.D., University of Amsterdam, 1933.

Interim Enabling Certificate Granted:

Antoine Mauriello, final year student, University of Montreal.

Enabling Certificates Deferred:

Markus Scherz, M.D., University of Brussels, 1941.

Peter Suderman, M.D., University of Gottingen, 1950.

Certificate of Registration Approved:

Simon Witt, M.R.C.S., England, 1939; L.R.C.P., London, 1939; M.B., B.S., University of London, 1940; F.R.C.S., Edinburgh, 1949.

Certificate of Licence Approved:

Anthony John Paul Proust, M.B., B.S., University of Sydney, 1948.

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